

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Community Alternatives

4 (Amended After Comments)

5 907 KAR 1:835. Michelle P. waiver services and reimbursement.

6 RELATES TO: KRS 205.520(3), 205.5605, 205.5606, 205.5607, 205.635, 42 C.F.R.

7 440.180

8 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.5606,

9 42 C.F.R. 440.180, 42 U.S.C. 1396a, 1396b, 1396d, 1396n

10 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family
11 Services, Department for Medicaid Services has responsibility to administer the
12 Medicaid Program. KRS 205.520(3) authorizes the cabinet to comply with any
13 requirement that may be imposed, or opportunity presented, by federal law to qualify for
14 federal Medicaid funds~~[the provision of medical assistance to Kentucky's indigent~~
15 ~~citizenry]~~. This administrative regulation establishes the coverage and reimbursement
16 provisions for Michelle P. waiver services.

17 Section 1. Definitions. (1) "ADHC" means adult day health care.

18 (2) "ADHC center" means an adult day health care center licensed in accordance
19 with 902 KAR 20:066.

20 (3) "ADHC services" means health-related services provided on a regularly-
21 scheduled basis that ensure optimal functioning of a Michelle P. waiver recipient who

1 does not require twenty-four (24) hour care in an institutional setting.

2 (4) "Advanced practice registered nurse[~~practitioner~~]" or "APRN[~~ARNP~~]" means a
3 person who acts within his or her scope of practice and is licensed in accordance with
4 KRS 314.042.

5 (5) "Assessment team" means a team which:

6 (a) Conducts assessment or reassessment services; and

7 (b) Consists of:

8 1. Two (2) registered nurses; or

9 2. One (1) registered nurse and one (1) of the following:

10 a. A social worker;

11 b. A certified psychologist with autonomous functioning;

12 c. A licensed psychological practitioner;

13 d. A licensed marriage and family therapist; or

14 e. A licensed professional clinical counselor.

15 (6) "Behavioral support specialist" means an individual who has:

16 (a) A master's degree from an accredited institution with formal graduate course
17 work in a behavioral science; and

18 (b) At least one (1) year of experience in behavioral programming.

19 (7) "Blended services" means a nonduplicative combination of Michelle P. waiver
20 services identified in Section 7 of this administrative regulation and consumer-directed
21 option services identified in Section 8 of this administrative regulation provided pursuant
22 to a recipient's approved plan of care.

23 (8) "Budget allowance" is defined by KRS 205.5605(1).

1 (9) [~~"Certified psychologist with autonomous functioning" or "licensed~~
2 ~~psychological practitioner" means a person licensed pursuant to KRS Chapter~~
3 ~~319.~~

4 ~~(10)~~ "Communicable disease" means a disease that is transmitted:

5 (a) Through direct contact with an infected individual;

6 (b) Indirectly through an organism that carries disease-causing microorganisms from
7 one (1) host to another; or

8 (c) Indirectly by a bacteriophage, a plasmid, or another agent that transfers genetic
9 material from one (1) location to another.

10 ~~(10)~~~~(11)~~ "Consumer" is defined by KRS 205.5605(2).

11 ~~(11)~~~~(12)~~ "Consumer-directed option" or "CDO" means an option established by
12 KRS 205.5606 within the home and community-based service waivers which allows
13 recipients to:

14 (a) Assist with the design of their programs;

15 (b) Choose their providers of services; and

16 (c) Direct the delivery of services to meet their needs.

17 ~~(12)~~~~(13)~~ "Covered services and supports" is defined by KRS 205.5605(3).

18 ~~(13)~~~~(14)~~ "DCBS" means the Department for Community Based Services.

19 ~~(14)~~~~(15)~~ "Department" means the Department for Medicaid Services or its
20 designee.

21 ~~(15)~~~~(16)~~ "Developmental disability" means a severe, chronic disability that:

22 (a) Is attributable to:

23 1. Cerebral palsy or epilepsy; or

1 2. Any other condition, excluding mental illness, closely related to an intellectual
2 disability resulting in impairment of general intellectual functioning or adaptive behavior
3 similar to that of an individual with an intellectual disability and which requires treatment
4 or services similar to those required by persons with an intellectual disability;

5 (b) Is manifested prior to the individual's 22nd birthday;

6 (c) Is likely to continue indefinitely; and

7 (d) Results in substantial functional limitations in three (3) or more of the following
8 areas of major life activity:

9 1. Self-care;

10 2. Understanding and use of language;

11 3. Learning;

12 4. Mobility;

13 5. Self-direction; or

14 6. Capacity for independent living.

15 **(16)~~(17)~~** "Direct-contact staff" means an individual hired by a Michelle P. waiver
16 provider to provide services to the recipient and who:

17 (a)1.a. Is eighteen (18) years of age or older; and

18 b. Has a high school diploma or GED; or

19 2.a. Is twenty-one (21) years of age or older; and

20 b. Is able to communicate with a recipient in a manner that the recipient or
21 recipient's legal representative or family member can understand;

22 (b) Has a valid Social Security number or valid work permit if not a U.S. citizen;

23 (c) Can understand and carry out simple instructions;

1 (d) Has the ability to keep simple records; and

2 (e) Is managed by the provider's supervisory staff.

3 ~~(17)~~~~(18)~~ "Electronic signature" is defined by KRS 369.102(8).

4 ~~(18)~~~~(19)~~ "Federal financial participation" is defined in 42 C.F.R. 400.203.

5 ~~(19)~~~~(20)~~ "Home health agency" means an agency that is:

6 (a) Licensed in accordance with 902 KAR 20:081; and

7 (b) Medicare and Medicaid certified.

8 ~~(20)~~~~(21)~~~~(20)~~ "ICF-IID" means an intermediate care facility for individuals with an
9 intellectual disability.

10 ~~(21)~~~~(22)~~~~(21)~~ "Intellectual disability" means an individual has:

11 (a) Significantly sub-average intellectual functioning;

12 (b) An intelligence quotient of seventy (70) or below;

13 (c) Concurrent deficits~~[diffieits]~~ or impairments in present adaptive functioning in at
14 least two (2) of the following areas:

15 1. Communication;

16 2. Self-care;

17 3. Home living;

18 4. Social or interpersonal skills;

19 5. Use of community resources;

20 6. Self-direction;

21 7. Functional academic skills;

22 8. Work;

23 9. Leisure; or

1 10. Health and safety; and

2 (d) Had an onset prior to eighteen (18) years of age.

3 ~~(22)~~~~(23)~~~~(22)~~ "Level of care determination" means a determination that an
4 individual meets the Michelle P. waiver service level of care criteria established in
5 Section 5 of this administrative regulation.

6 ~~(23)~~~~(24)~~~~(23)~~ "Licensed marriage and family therapist" or "LMFT" is defined by
7 KRS 335.300(2).

8 ~~(24)~~~~(25)~~~~(24)~~ "Licensed practical nurse" or "LPN" means a person who:

9 (a) Meets the definition of KRS 314.011(9); and

10 (b) Works under the supervision of a registered nurse.

11 ~~(25)~~~~(26)~~~~(25)~~ "Licensed professional clinical counselor" or "LPCC" is defined by
12 KRS 335.500(3).

13 **(26) "Licensed psychologist" means an individual who:**

14 **(a) Currently possesses a licensed psychologist licensed in accordance with**

15 **KRS 319.010(6); and**

16 **(b) Meets the licensed psychologist requirements established in 201 KAR**

17 **Chapter 26.**

18 **(27) "Licensed psychological practitioner" means an individual who:**

19 **(a) Meets the requirements established in KRS 319.053; or**

20 **(b) Is a certified psychologist with autonomous functioning.**

21 ~~(28)~~~~(26)~~

22 ~~(26)~~ "Michelle P. recipient" means an individual who:

23 (a) Is a recipient as defined by KRS 205.8451(9);

1 (b) Meets the Michelle P. waiver service level of care criteria established in Section
2 5 of this administrative regulation; and

3 (c) Meets the eligibility criteria for Michelle P. waiver services established in Section
4 4 of this administrative regulation.

5 ~~(29)~~~~(28)~~~~(27)~~ "Normal baby sitting" means general care provided to a child which
6 includes custody, control, and supervision.

7 ~~(30)~~~~(29)~~~~(28)~~ "Occupational therapist" is defined by KRS 319A.010(3).

8 ~~(31)~~~~(30)~~~~(29)~~ "Occupational therapy assistant" is defined by KRS 319A.010(4).

9 ~~(32)~~~~(31)~~~~(30)~~ "Patient liability" means the financial amount an individual is required
10 to contribute toward cost of care in order to maintain Medicaid eligibility.

11 ~~(33)~~~~(32)~~~~(31)~~ "Physical therapist" is defined by KRS 327.010(2).

12 ~~(34)~~~~(33)~~~~(32)~~ "Physical therapist assistant" means a skilled health care worker
13 who:

14 (a) Is certified by the Kentucky Board of Physical Therapy; and

15 (b) Performs physical therapy and related duties as assigned by the supervising
16 physical therapist.

17 ~~(35)~~~~(34)~~~~(33)~~ "Physician assistant" or "PA" is defined by KRS 311.840(3).

18 ~~(36)~~~~(35)~~~~(34)~~ "Plan of care" or "POC" means a written individualized plan
19 developed by:

20 (a) A Michelle P. recipient or a Michelle P. recipient's legal representative;

21 (b) The case manager or support broker; and

22 (c) Any other person designated by the Michelle P. recipient if the Michelle P.
23 recipient designates another person.

1 ~~(37)~~~~(36)~~~~(35)~~ "Plan of treatment" means a care plan used by an ADHC center.

2 ~~(38)~~~~(37)~~~~(36)~~ "Psychologist" is defined by KRS 319.010(8).

3 ~~(39)~~~~(38)~~~~(37)~~ "Psychologist with autonomous functioning" means an individual who

4 is licensed in accordance with KRS 319.056.

5 ~~(40)~~~~(39)~~~~(38)~~ "Qualified Intellectual Disability Professional" or "QIDP" is defined by

6 KRS 202B.010(12).

7 ~~(41)~~~~(40)~~~~(39)~~ "Registered nurse" or "RN" means a person who:

8 (a) Meets the definition established in KRS 314.011(5); and

9 (b) Has one (1) year or more experience as a professional nurse.

10 ~~(42)~~~~(41)~~~~(40)~~ "Representative" is defined by KRS 205.5605(6).

11 ~~(43)~~~~(42)~~~~(41)~~ "SCL waiting list individual" means an individual on the Supports for

12 Community Living (SCL) waiting list pursuant to 907 KAR 1:145, Section 7.

13 ~~(44)~~~~(43)~~~~(42)~~ "Sex crime" is defined by KRS 17.165(1).

14 ~~(45)~~~~(44)~~~~(43)~~ "Social worker" means a person with a bachelor's degree in social

15 work, sociology, or a related field.

16 ~~(46)~~~~(45)~~~~(44)~~ "Speech-language pathologist" is defined by KRS 334A.020(3).

17 **(47) "State plan" is defined by 42 C.F.R. 400.203.**

18 ~~(48)~~~~(46)~~~~(45)~~ "Supervisory staff" means an individual employed by the Michelle P.

19 waiver provider who shall manage direct-care staff and who:

20 (a)1.a. Is eighteen (18) years of age or older; and

21 b. Has a high school diploma; or

22 2.a. Is twenty-one (21) years of age or older; and

23 b. Has a minimum of one (1) year experience in providing services to individuals

1 with an intellectual or developmental disability;

2 (b) Is able to adequately communicate with the recipients, staff, and family
3 members;

4 (c) Has a valid Social Security number or valid work permit if not a U.S. citizen; and

5 (d) Has the ability to perform required record keeping.

6 ~~(49)(47)(46)~~ "Support broker" means an individual chosen by a consumer from an
7 agency designated by the department to:

8 (a) Provide training, technical assistance, and support to a consumer; and

9 (b) Assist a consumer in any other aspects of CDO.

10 ~~(50)(48)(47)~~ "Support spending plan" means a plan for a consumer that identifies
11 the:

12 (a) CDO services requested;

13 (b) Employee name;

14 (c) Hourly wage;

15 (d) Hours per month;

16 (e) Monthly pay;

17 (f) Taxes;

18 (g) Budget allowance; and

19 (h) Six (6)-month budget.

20 ~~(51)(49)(48)~~ "Violent crime" is defined by KRS 17.165(3).

21 Section 2. Non-CDO Provider Participation. (1) In order to provide Michelle P. waiver
22 services, excluding consumer-directed option services, a provider shall be:

23 (a) Licensed in accordance with:

- 1 1. 902 KAR 20:066 if an adult day health care provider;
- 2 2. 902 KAR 20:078 if a group home;
- 3 3. 902 KAR 20:081 if a home health service provider; or
- 4 4. 902 KAR 20:091 if a community mental health center; or
- 5 (b) Be certified by the department in accordance with 907 KAR 1:145, Section 3, if a
- 6 provider type not listed in paragraph (a) of this subsection.
- 7 (2) A Michelle P. waiver service provider shall:
- 8 (a) Provide services to Michelle P. waiver recipients:
- 9 1. Directly; or
- 10 2. Indirectly through a subcontractor;
- 11 (b) Comply with the following administrative regulations and program requirements:
- 12 1. 907 KAR 1:671;
- 13 2. 907 KAR 1:672; and
- 14 3. 907 KAR 1:673;
- 15 (c) Not enroll a Michelle P. recipient for whom the provider is unequipped or unable
- 16 to provide Michelle P. waiver services; and
- 17 (d) Be permitted to accept or not accept a Michelle P. recipient.
- 18 Section 3. Maintenance of Records. (1) A Michelle P. waiver provider shall maintain:
- 19 (a) A clinical record for each Michelle P. recipient that shall contain the following:
- 20 1. Pertinent medical, nursing, and social history;
- 21 2. A comprehensive assessment entered on form MAP-351 and signed by the:
- 22 a. Assessment team; and
- 23 b. Department;

- 1 3. A completed MAP 109;
- 2 4. A copy of the MAP-350 signed by the recipient or his or her legal representative
- 3 at the time of application or reapplication and each recertification thereafter;
- 4 5. The name of the case manager;
- 5 6. Documentation of all level of care determinations;
- 6 7. All documentation related to prior authorizations, including requests, approvals,
- 7 and denials;
- 8 8. Documentation of each contact with, or on behalf of, a Michelle P. recipient;
- 9 9. Documentation that the Michelle P. recipient receiving ADHC services or legal
- 10 representative was provided a copy of the ADHC center's posted hours of operation;
- 11 10. Documentation that the recipient or legal representative was informed of the
- 12 procedure for reporting complaints; and
- 13 11. Documentation of each service provided. The documentation shall include:
- 14 a. The date the service was provided;
- 15 b. The duration of the service;
- 16 c. The arrival and departure time of the provider, excluding travel time, if the service
- 17 was provided at the Michelle P. waiver recipient's home;
- 18 d. Itemization of each service delivered;
- 19 e. The Michelle P. recipient's arrival and departure time, excluding travel time, if the
- 20 service was provided outside the recipient's home;
- 21 f. Progress notes which shall include documentation of changes, responses, and
- 22 treatments utilized to meet the Michelle P. recipient's needs; and
- 23 g. The signature of the service provider; and

1 (b) Fiscal reports, service records, and incident reports regarding services provided.

2 The reports and records shall be retained for the longer of:

3 1. At least six (6) years from the date that a covered service is provided; or

4 2. For a minor, three (3) years after the recipient reaches the age of majority under
5 state law.

6 (2) Upon request, a Michelle P. provider shall make information regarding service
7 and financial records available to the:

8 (a) Department;

9 (b) Kentucky Cabinet for Health and Family Services, Office of Inspector General or
10 its designee;

11 (c) United States Department for Health and Human Services or its designee;

12 (d) United States Government Accountability Office or its designee;

13 (e) Kentucky Office of the Auditor of Public Accounts or its designee; or

14 (f) Kentucky Office of the Attorney General or its designee.

15 Section 4. Michelle P. Recipient Eligibility Determinations and Redeterminations. (1)

16 A Michelle P. waiver service shall be provided to a Medicaid-eligible Michelle P.

17 recipient who:

18 (a) Is determined by the department to meet the Michelle P. waiver service level of
19 care criteria in accordance with Section 5 of this administrative regulation; and

20 (b) Would, without waiver services, be admitted to an ICF-IID~~[ICF-MR-DD]~~ or a
21 nursing facility.

22 (2) The department shall perform a Michelle P. waiver service level of care
23 determination for each Michelle P. recipient at least once every twelve (12) months or

1 more often if necessary.

2 (3) A Michelle P. waiver service shall not be provided to an individual who:

3 (a) Does not require a service other than:

4 1. An environmental and minor home adaptation;

5 2. Case management; or

6 3. An environmental and minor home adaptation and case management;

7 (b) Is an inpatient of:

8 1. A hospital;

9 2. A nursing facility; or

10 3. An ICF-IID~~(ICF-MR-DD)~~;

11 (c) Is a resident of a licensed personal care home; or

12 (d) Is receiving services from another Medicaid home and community based
13 services waiver program.

14 (4) A Michelle P. waiver provider shall inform a Michelle P. recipient or his legal
15 representative of the choice to receive:

16 (a) Michelle P. waiver services; or

17 (b) Institutional services.

18 (5) An eligible Michelle P. recipient or the recipient's legal representative shall select
19 a participating Michelle P. waiver provider from which the recipient wishes to receive
20 Michelle P. waiver services.

21 (6) A Michelle P. waiver provider shall use a MAP-24 to notify the department of a
22 Michelle P. service recipient's:

23 (a) Termination from the Michelle P. waiver program; or

1 (b)1. Admission to an ICF-IID~~[ICF-MR-DD]~~ or nursing facility for less than sixty (60)
2 consecutive days; or

3 2. Return to the Michelle P. waiver program from an ICF-IID~~[ICF-MR-DD]~~ or nursing
4 facility within sixty (60) consecutive days;

5 (c) Admission to a hospital; or

6 (d) Transfer to another waiver program within the department.

7 (7) Involuntary termination of a service to a Michelle P. recipient by a Michelle P.
8 provider shall require:

9 (a) Simultaneous notice to the recipient or legal representative, the case manager or
10 support broker, and the department at least thirty (30) days prior to the effective date of
11 the action, which shall include:

12 1. A statement of the intended action;

13 2. The basis for the intended action;

14 3. The authority by which the action is taken; and

15 4. The recipient's right to appeal the intended action through the provider's appeal or
16 grievance process;

17 (b) Submittal of a MAP-24 to the department at the time of the intended action; and

18 (c) The case manager or support broker in conjunction with the provider to:

19 1. Provide the recipient with the name, address, and telephone number of each
20 current provider in the state;

21 2. Provide assistance to the recipient in making contact with another provider;

22 3. Arrange transportation for a requested visit to a provider site;

23 4. Provide a copy of pertinent information to the recipient or legal representative;

1 5. Ensure the health, safety, and welfare of the recipient until an appropriate
2 placement is secured;

3 6. Continue to provide supports until alternative services are secured; and

4 7. Provide assistance to ensure a safe and effective service transition.

5 Section 5. Michelle P. Waiver Service Level of Care Criteria. (1) An individual shall
6 be determined to have met the Michelle P. waiver service level of care criteria if the
7 individual:

8 (a) Requires physical or environmental management or rehabilitation and:

9 1. Has a developmental disability or significantly sub-average intellectual
10 functioning;

11 2. Requires a protected environment while overcoming the effects of a
12 developmental disability or sub-average intellectual functioning while:

13 a. Learning fundamental living skills;

14 b. Obtaining educational experiences which will be useful in self-supporting
15 activities; or

16 c. Increasing awareness of his or her environment; or

17 3. Has a primary psychiatric diagnosis if:

18 a. Possessing care needs listed in subparagraph 1 or 2 of this paragraph;

19 b. The individual's mental care needs are adequately handled in an ICF-IID~~[ICF-MR-~~
20 ~~DD]~~; and

21 c. The individual does not require psychiatric inpatient treatment.

22 (b) Has a developmental disability and meets the:

23 1. High-intensity nursing care patient status criteria pursuant to 907 KAR 1:022,

1 Section 4(2); or

2 2. Low-intensity nursing care patient status criteria pursuant to 907 KAR 1:022,
3 Section 4(3).

4 (2) An individual who does not require a planned program of active treatment to
5 attain or maintain an optimal level of functioning shall not meet the Michelle P. waiver
6 service level of care criteria.

7 (3) The department shall not determine that an individual fails to meet the Michelle
8 P. waiver service level of care criteria solely due to the individual's age, length of stay in
9 an institution, or history of previous institutionalization if the individual meets the criteria
10 established in subsection (1) of this section.

11 Section 6. Enrollment. (1) The department shall enroll an individual on a 1st priority
12 basis if the individual:

13 (a) Has an urgent need pursuant to 907 KAR 1:145, section 7(7)(b), regardless of
14 whether the individual is on the SCL waiting list; and

15 (b) Meets the eligibility criteria established in Section 4 of this administrative
16 regulation.

17 (2) After all first priority basis individuals have been enrolled, the department shall
18 enroll remaining SCL waiting list individuals who meet the eligibility criteria established
19 in Section 4 of this administrative regulation in accordance with the SCL waiting list
20 provisions established in 907 KAR 1:145, Section 7.

21 (3) After all individuals have been enrolled pursuant to subsections (1) and (2) of this
22 Section, the department shall utilize a first come, first served priority basis to enroll an
23 individual who meets the eligibility criteria established in Section 4 of this administrative

1 regulation.

2 (4) The number of individuals enrolled and receiving services in [department shall
3 enroll into] the Michelle P. waiver program shall not exceed the limit of individuals
4 established for the program by the Centers for Medicare and Medicaid Services[ne
5 more than:

6 (a) ~~3,000 individuals during the first state fiscal year (beginning July 1, 2008);~~

7 (b) ~~A total of 4,500 individuals by the end of the second state fiscal year (June 30,~~
8 ~~2010); and~~

9 (c) ~~A total of 6,000 individuals by the end of the third state fiscal year (June 30,~~
10 ~~2011)].~~

11 Section 7. Covered Services. (1) A Michelle P. waiver service shall:

12 (a) Be prior authorized by the department to ensure that the service or modification
13 of the service meets the needs of the Michelle P. recipient;

14 (b) Be provided pursuant to a plan of care or, for a CDO service, pursuant to a plan
15 of care and support spending plan;

16 (c) Except for a CDO service, not be provided by a member of the Michelle P.
17 recipient's family. A CDO service may be provided by a Michelle P. recipient's family
18 member; and

19 (d) Shall be accessed within sixty (60) days of the date of prior authorization.

20 (2) To request prior authorization, a provider shall submit a completed MAP 10,
21 MAP 109, and MAP 351 to the department.

22 (3) Covered Michelle P. waiver services shall include:

23 (a) A comprehensive assessment which shall:

- 1 1. Be completed by the department;
- 2 2. Identify a Michelle P. waiver recipient's needs and the services the Michelle P.
3 waiver recipient or the recipient's family cannot manage or arrange for on the recipient's
4 behalf;
- 5 3. Evaluate a Michelle P. waiver recipient's physical health, mental health, social
6 supports, and environment;
- 7 4. Be requested by an individual seeking Michelle P. waiver services or the
8 individual's family, legal representative, physician, physician assistant, QDIP, or ARNP;
- 9 5. Be conducted by an assessment team; and
- 10 6. Include at least one (1) face-to-face home visit by a member of the assessment
11 team with the Michelle P. waiver recipient and, if appropriate, the recipient's family;
- 12 (b) A reassessment service which shall:
 - 13 1. Be completed by the department;
 - 14 2. Determine the continuing need for Michelle P. waiver services and, if appropriate,
15 CDO services;
 - 16 3. Be performed at least every twelve (12) months;
 - 17 4. Be conducted using the same procedures used in an assessment service; and
 - 18 5. Not be retroactive;
- 19 (c) A case management service which:
 - 20 1. Shall consist of coordinating the delivery of direct and indirect services to a
21 Michelle P. waiver recipient;
 - 22 2. Shall be provided by a case manager who shall:
 - 23 a. Arrange for a service but not provide a service directly, except as allowed in

- 1 subparagraph 8 of this paragraph;
- 2 b. Contact the Michelle P. waiver recipient monthly through a face-to-face visit at the
3 Michelle P. recipient's home, in the ADHC center, or the adult day training provider's
4 location.
- 5 c. Assure that service delivery is in accordance with a Michelle P. waiver recipient's
6 plan of care; and
- 7 d. Meet the requirements of subsection (4) of this section;
- 8 3. Shall not include a group conference;
- 9 4. Shall include development of a plan of care that shall:
- 10 a. Be completed on the MAP 109 using Person Centered Planning: Guiding
11 Principles;
- 12 b. Reflect the needs of the Michelle P. recipient;
- 13 c. List goals, interventions, and outcomes;
- 14 d. Specify services needed;
- 15 e. Determine the amount, frequency, and duration of services;
- 16 f. Provide for reassessment at least every twelve (12) months;
- 17 g. Be developed and signed by the case manager and Michelle P. waiver recipient,
18 family member, or legal representative; and
- 19 h. Be submitted to the department no later than thirty (30) calendar days after
20 receiving the department's approval of the Michelle P. waiver service level of care;
- 21 5. Shall include documentation with a detailed monthly summary note which
22 includes:
- 23 a. The month, day, and year for the time period each note covers;

1 b. Progression, regression, and maintenance toward outcomes identified in the plan
2 of care;

3 c. The signature, date of signature, and title of the individual preparing the note; and

4 d. Documentation of at least one (1) face-to-face meeting between the case
5 manager and Michelle P. waiver recipient, family member, or legal representative;

6 6. Shall include requiring a Michelle P. recipient or legal representative to sign a
7 MAP-350 form at the time of application or reapplication and at each recertification to
8 document that the individual was informed of the choice to receive Michelle P. waiver or
9 institutional services; and

10 7. Shall not be provided to a recipient by an agency if the agency provides any other
11 Michelle P. waiver service to the recipient[, ~~except as allowed in subparagraph 8 of this~~
12 ~~paragraph; and~~

13 ~~8. Contingent upon approval by the Centers for Medicare and Medicaid Services~~
14 ~~and expiring January 1, 2011, may be provided by an agency which also provides any~~
15 ~~other Michelle P. waiver service to the recipient if the agency meets the provider~~
16 ~~qualifications established in Section 2 of this administrative regulation and:~~

17 ~~a. Provided case management to the recipient in another of the department's waiver~~
18 ~~programs prior to the establishment of the Michelle P. waiver service program; or~~

19 ~~b. Provided other services via the Cabinet for Health and Family Services to the~~
20 ~~recipient prior to the establishment of the Michelle P. waiver service program].~~

21 (d) A homemaker service which shall consist of general household activities and
22 shall:

23 1. Be provided by direct-care staff;

- 1 2. Be provided to a Michelle P. waiver recipient:
- 2 a. Who is functionally unable, but would normally perform age-appropriate
- 3 homemaker tasks; and
- 4 b. If the caregiver regularly responsible for homemaker activities is temporarily
- 5 absent or functionally unable to manage the homemaking activities; and
- 6 3. Include documentation with a detailed note which shall include:
- 7 a. The month, day, and year for the time period each note covers;
- 8 b. Progression, regression, and maintenance toward outcomes identified in the plan
- 9 of care; and
- 10 c. The signature, date of signature, and title of the individual preparing the note;
- 11 (e) A personal care service which shall:
- 12 1. Be age appropriate;
- 13 2. Consist of assisting a recipient with eating, bathing, dressing, personal hygiene,
- 14 or other activities of daily living;
- 15 3. Be provided by direct-care staff;
- 16 4. Be provided to a Michelle P. recipient:
- 17 a. Who does not need highly skilled or technical care;
- 18 b. For whom services are essential to the recipient's health and welfare and not for
- 19 the recipient's family; and
- 20 c. Who needs assistance with age-appropriate activities of daily living; and
- 21 5. Include documentation with a detailed note which shall include:
- 22 a. The month, day, and year for the time period each note covers;
- 23 b. Progression, regression, and maintenance toward outcomes identified in the plan

- 1 of care;
- 2 c. The signature, date of signature, and title of the individual preparing the note; and
- 3 d. The beginning and ending time of service;
- 4 (f) An attendant care service which shall consist of hands-on care that is:
- 5 1. Provided by direct-care staff to a Michelle P. waiver recipient who:
- 6 a. Is medically stable but functionally dependent and requires care or supervision
- 7 twenty-four (24) hours per day; and
- 8 b. Has a family member or other primary caretaker who is employed and not able to
- 9 provide care during working hours;
- 10 2. Not of a general housekeeping nature;
- 11 3. Not provided to a Michelle P. waiver recipient who is receiving any of the following
- 12 Michelle P. waiver services:
- 13 a. Personal care;
- 14 b. Homemaker;
- 15 c. ADHC;
- 16 d. Adult day training;
- 17 e. Community living supports; or
- 18 f. Supported employment; and
- 19 4. Include documentation with a detailed note which shall include:
- 20 a. The month, day, and year for the time period each note covers;
- 21 b. Progression, regression, and maintenance toward outcomes identified in the plan
- 22 of care;
- 23 c. The signature, date of signature, and title of the individual preparing the note; and

- 1 d. Beginning and ending time of service;
- 2 (g) A respite care service which shall be short term care based on the absence or
3 need for relief of the primary caretaker and be:
- 4 1. Provided by direct-care staff who provide services at a level which appropriately
5 and safely meet the medical needs of the Michelle P. waiver recipient;
- 6 2. Provided to a Michelle P. waiver recipient who has care needs beyond normal
7 baby sitting;
- 8 3. Used no less than every six (6) months;
- 9 4. Provided in accordance with 902 KAR 20:066, Section 2(1)(b)10a through c, if
10 provided to a child under age 21 (twenty-one) in an ADHC center; and
- 11 5. Include documentation with a detailed note which shall include:
- 12 a. The month, day, and year for the time period each note covers;
- 13 b. ~~Progression, regression, and maintenance toward outcomes identified in~~
14 ~~the plan of care;~~
- 15 ~~c.]~~ The signature, date of signature, and title of the individual preparing the note;
16 and
- 17 ~~c. [d.]~~ The beginning and ending time of service;
- 18 (h) An environmental and minor home adaptation service which shall be a physical
19 adaptation to a home that is necessary to ensure the health, welfare, and safety of a
20 Michelle P. waiver recipient and which shall:
- 21 1. Meet all applicable safety and local building codes;
- 22 2. Relate strictly to the Michelle P. waiver recipient's disability and needs;
- 23 3. Exclude an adaptation or improvement to a home that has no direct medical or

- 1 remedial benefit to the Michelle P. waiver recipient;
- 2 4. Be submitted on form MAP-95 for prior authorization; and
- 3 5. Include documentation with a detailed note which shall include:
- 4 a. The month, day, and year for the time period each note covers; and
- 5 b. ~~[Progression, regression, and maintenance toward outcomes identified in~~
- 6 ~~the plan of care; and~~
- 7 e.] The signature, date of signature, and title of the individual preparing the note;
- 8 (i) Occupational therapy which shall be:
- 9 1. A physician ordered evaluation of a Michelle P. waiver recipient's level of
- 10 functioning by applying diagnostic and prognostic tests;
- 11 2. Physician-ordered services in a specified amount and duration to guide a Michelle
- 12 P. waiver recipient in the use of therapeutic, creative, and self-care activities to assist
- 13 the recipient in obtaining the highest possible level of functioning;
- 14 3. Training of other Michelle P. waiver providers on improving the level of
- 15 functioning;
- 16 4. Exclusive of maintenance or the prevention of regression;
- 17 5. Provided by an occupational therapist or an occupational therapy assistant
- 18 supervised by an occupational therapist in accordance with 201 KAR 28:130; and
- 19 6. Documented with a detailed staff note which shall include:
- 20 a. The month, day, and year for the time period each note covers;
- 21 b. Progression, regression, and maintenance toward outcomes identified in the plan
- 22 of care; and
- 23 c. The signature, date of signature, and title of the individual preparing the note;

- 1 (j) Physical therapy which shall:
- 2 1. Be a physician-ordered evaluation of a Michelle P. waiver recipient by applying
- 3 muscle, joint, and functional ability tests;
- 4 2. Be physician-ordered treatment in a specified amount and duration to assist a
- 5 Michelle P. waiver recipient in obtaining the highest possible level of functioning;
- 6 3. Include training of other Michelle P. waiver providers on improving the level of
- 7 functioning;
- 8 4. Be exclusive of maintenance or the prevention of regression;
- 9 5. Be provided by a physical therapist or a physical therapist assistant supervised by
- 10 a physical therapist in accordance with 201 KAR 22:001 and 201 KAR 22:053; and
- 11 6. Be documented with a detailed monthly summary note which shall include:
- 12 a. The month, day, and year for the time period each note covers;
- 13 b. Progression or lack of progression toward outcomes identified in the plan of care;
- 14 and
- 15 c. The signature, date of signature, and title of the individual preparing the note;
- 16 (k) Speech therapy which shall:
- 17 1. Be a physician-ordered evaluation of a Michelle P. waiver recipient with a speech
- 18 or language disorder;
- 19 2. Be a physician-ordered habilitative service in a specified amount and duration to
- 20 assist a Michelle P. waiver recipient with a speech and language disability in obtaining
- 21 the highest possible level of functioning;
- 22 3. Include training of other Michelle P. waiver providers on improving the level of
- 23 functioning;

- 1 4. Be provided by a speech-language pathologist; and
- 2 5. Be documented with a detailed monthly summary note which shall include:
 - 3 a. The month, day, and year for the time period each note covers;
 - 4 b. Progression, regression, and maintenance toward outcomes identified in the plan
 - 5 of care; and
 - 6 c. The signature, date of signature, and title of the individual preparing the note;
- 7 (l) An adult day training service which shall:
 - 8 1. Support the Michelle P. waiver recipient in daily, meaningful routines in the
 - 9 community;
 - 10 2. Stress training in:
 - 11 a. The activities of daily living;
 - 12 b. Self-advocacy;
 - 13 c. Adaptive and social skills; and
 - 14 d. Vocational skills;
 - 15 3. Be provided in a community setting which may:
 - 16 a. Be a fixed location; or
 - 17 b. Occur in public venues;
 - 18 4. Not be diversional in nature;
 - 19 5. If provided on site:
 - 20 a. Include facility-based services provided on a regularly-scheduled basis;
 - 21 b. Lead to the acquisition of skills and abilities to prepare the recipient for work or
 - 22 community participation; or
 - 23 c. Prepare the recipient for transition from school to work or adult support services;

- 1 6. If provided off site:
- 2 a. Include services provided in a variety of community settings;
- 3 b. Provide access to community-based activities that cannot be provided by natural
- 4 or other unpaid supports;
- 5 c. Be designed to result in increased ability to access community resources without
- 6 paid supports;
- 7 d. Provide the opportunity for the recipient to be involved with other members of the
- 8 general population; and
- 9 e. Be provided as:
- 10 (i) An enclave or group approach to training in which recipients work as a group or
- 11 are dispersed individually throughout an integrated work setting with people without
- 12 disabilities;
- 13 (ii) A mobile crew performing work in a variety of community businesses or other
- 14 community settings with supervision by the provider; or
- 15 (iii) An entrepreneurial or group approach to training for participants to work in a
- 16 small business created specifically by or for the recipient or recipients;
- 17 7. Ensure that any recipient performing productive work that benefits the
- 18 organization, be paid commensurate with compensation to members of the general
- 19 work force doing similar work;
- 20 8. Require that an adult day training service provider conduct, at least annually, an
- 21 orientation informing the recipient of supported employment and other competitive
- 22 opportunities in the community;
- 23 9. Be provided at a time mutually agreed to by the recipient and Michelle P. waiver

- 1 provider;
- 2 10.a. Be provided to recipients age twenty-two (22) or older; or
- 3 b. Be provided to recipients age sixteen (16) to twenty-one (21) as a transition
- 4 process from school to work or adult support services; and
- 5 11. Be documented with:
- 6 a. A detailed monthly summary note which shall include:
- 7 (i) The month, day, and year for the time period each note covers;
- 8 (ii) Progression, regression, and maintenance toward outcomes identified in the plan
- 9 of care; and
- 10 (iii) The signature, date of signature, and title of the individual preparing the note;
- 11 and
- 12 b. A time and attendance record which shall include:
- 13 (i) The date of service;
- 14 (ii) The beginning and ending time of the service;
- 15 (iii) The location of the service; and
- 16 (iv) The signature, date of signature, and title of the individual providing the service;
- 17 (m) A supported employment service which shall:
- 18 1. Be intensive, ongoing support for a Michelle P. waiver recipient to maintain paid
- 19 employment in an environment in which an individual without a disability is employed;
- 20 2. Include attending to a recipient's personal care needs;
- 21 3. Be provided in a variety of settings;
- 22 4. Be provided on a one-to-one basis;
- 23 5. Be unavailable under a program funded by either 29 U.S.C. Chapter 16 or 34

- 1 C.F.R. Subtitle B, Chapter III (34 C.F.R. Parts 300 to 399), proof of which shall be
2 documented in the Michelle P. waiver recipient's file;
- 3 6. Exclude work performed directly for the supported employment provider;
- 4 7. Be provided by a staff person who has completed a supported employment
5 training curriculum conducted by staff of the cabinet or its designee;
- 6 8. Be documented by:
- 7 a. A detailed monthly summary note which shall include:
- 8 (i) The month, day, and year for the time period each note covers;
- 9 (ii) Progression, regression, and maintenance toward outcomes identified in the plan
10 of care; and
- 11 (iii) The signature, date of signature, and title of the individual preparing the note;
- 12 and
- 13 b. A time and attendance record which shall include:
- 14 (i) The date of service;
- 15 (ii) The beginning and ending time of the service;
- 16 (iii) The location of the service; and
- 17 (iv) The signature, date of signature, and title of the individual providing the service;
- 18 (n) A behavioral support service which shall:
- 19 1. Be the systematic application of techniques and methods to influence or change a
20 behavior in a desired way;
- 21 2. Be provided to assist the Michelle P. waiver recipient to learn new behaviors that
22 are directly related to existing challenging behaviors or functionally equivalent
23 replacement behaviors for identified challenging behaviors;

- 1 3. Include a functional assessment of the Michelle P. waiver recipient's behavior
- 2 which shall include:
- 3 a. An analysis of the potential communicative intent of the behavior;
- 4 b. The history of reinforcement for the behavior;
- 5 c. Critical variables that preceded the behavior;
- 6 d. Effects of different situations on the behavior; and
- 7 e. A hypothesis regarding the motivation, purpose, and factors which maintain the
- 8 behavior;
- 9 4. Include the development of a behavioral support plan which shall:
- 10 a. Be developed by the behavioral specialist;
- 11 b. Be implemented by Michelle P. waiver provider staff in all relevant environments
- 12 and activities;
- 13 c. Be revised as necessary;
- 14 d. Define the techniques and procedures used;
- 15 e. Be designed to equip the recipient to communicate his or her needs and to
- 16 participate in age-appropriate activities;
- 17 f. Include the hierarchy of behavior interventions ranging from the least to the most
- 18 restrictive;
- 19 g. Reflect the use of positive approaches; and
- 20 h. Prohibit the use of restraints, seclusion, corporal punishment, verbal abuse, and
- 21 any procedure which denies private communication, requisite sleep, shelter, bedding,
- 22 food, drink, or use of a bathroom facility;
- 23 5. Include the provision of training to other Michelle P. waiver providers concerning

- 1 implementation of the behavioral support plan;
- 2 6. Include the monitoring of a Michelle P. recipient's progress which shall be
3 accomplished by:
- 4 a. The analysis of data concerning the frequency, intensity, and duration of a
5 behavior; and
- 6 b. The reports of a Michelle P. waiver provider involved in implementing the behavior
7 support plan;
- 8 7. Provide for the design, implementation, and evaluation of systematic
9 environmental modifications;
- 10 8. Be provided by a behavior support specialist; and
- 11 9. Be documented by a detailed staff note which shall include:
- 12 a. The date of service;
- 13 b. The beginning and ending time; and
- 14 c. The signature, date of signature, and title of the behavioral specialist;
- 15 (o) An ADHC service which shall:
- 16 1. Be provided to a Michelle P. waiver recipient who is at least twenty-one (21) years
17 of age;
- 18 2. Include the following basic services and necessities provided to Medicaid waiver
19 recipients during the posted hours of operation:
- 20 a. Skilled nursing services provided by an RN or LPN, including ostomy care, urinary
21 catheter care, decubitus care, tube feeding, venipuncture, insulin injections,
22 tracheotomy care, or medical monitoring;
- 23 b. Meal service corresponding with hours of operation with a minimum of one (1)

- 1 meal per day and therapeutic diets as required;
- 2 c. Snacks;
- 3 d. Supervision by an RN;
- 4 e. Age and diagnosis appropriate daily activities; and
- 5 f. Routine services that meet the daily personal and health care needs of a Michelle
- 6 P. waiver recipient, including:
 - 7 (i) Monitoring of vital signs;
 - 8 (ii) Assistance with activities of daily living; and
 - 9 (iii) Monitoring and supervision of self-administered medications, therapeutic
 - 10 programs, and incidental supplies and equipment needed for use by a Michelle P.
 - 11 waiver recipient;
- 12 3. Include developing, implementing, and maintaining nursing policies for nursing or
- 13 medical procedures performed in the ADHC center;
- 14 4. Include respite care services pursuant to paragraph (g) of this subsection;
- 15 5. Be provided to a Michelle P. waiver recipient by the health team in an ADHC
- 16 center which may include:
 - 17 a. A physician;
 - 18 b. A physician assistant;
 - 19 c. An ARNP;
 - 20 d. An RN;
 - 21 e. An LPN;
 - 22 f. An activities director;
 - 23 g. A physical therapist;

- 1 h. A physical therapist assistant;
- 2 i. An occupational therapist;
- 3 j. An occupational therapist assistant;
- 4 k. A speech pathologist;
- 5 l. A social worker;
- 6 m. A nutritionist;
- 7 n. A health aide;
- 8 o. An LPCC;
- 9 p. An LMFT;
- 10 q. A certified psychologist with autonomous functioning; or
- 11 r. A licensed psychological practitioner; and
- 12 6. Be provided pursuant to a plan of treatment. The plan of treatment shall:
- 13 a. Be developed and signed by each member of the plan of treatment team which
- 14 shall include the recipient or a legal representative of the recipient;
- 15 b. Include pertinent diagnoses, mental status, services required, frequency of visits
- 16 to the ADHC center, prognosis, rehabilitation potential, functional limitation, activities
- 17 permitted, nutritional requirements, medication, treatment, safety measures to protect
- 18 against injury, instructions for timely discharge, and other pertinent information; and
- 19 c. Be developed annually from information on the MAP 351 and revised as needed;
- 20 and
- 21 (p) Community living supports which shall:
- 22 1. Be provided to facilitate independence and promote integration into the
- 23 community for an SCL recipient residing in his or her own home or in his or her family's

- 1 home;
- 2 2. Be supports and assistance which shall be related to chosen outcomes and not
- 3 be diversional in nature. This may include:
- 4 a. Routine household tasks and maintenance;
- 5 b. Activities of daily living;
- 6 c. Personal hygiene;
- 7 d. Shopping;
- 8 e. Money management;
- 9 f. Medication management;
- 10 g. Socialization;
- 11 h. Relationship building;
- 12 i. Leisure choices;
- 13 j. Participation in community activities;
- 14 k. Therapeutic goals; or
- 15 l. Nonmedical care not requiring nurse or physician intervention;
- 16 3. Not replace other work or day activities;
- 17 4. Be provided on a one-on-one basis;
- 18 5. Not be provided at an adult day-training or children's day- habilitation site;
- 19 6. Be documented by:
- 20 a. A time and attendance record which shall include:
- 21 (i) The date of the service;
- 22 (ii) The beginning and ending time of the service; and
- 23 (iii) The signature, date of signature and title of the individual providing the service;

1 and

2 b. A detailed monthly summary note which shall include:

3 (i) The month, day, and year for the time period each note covers;

4 (ii) Progression, regression, and maintenance toward outcomes identified in the plan
5 of care; and

6 (iii) The signature, date of signature, and title of the individual preparing the
7 summary note; and

8 7. Be limited to sixteen (16) hours per day alone or in combination with adult day
9 training, and supported employment.

10 (4) A case manager shall:

11 (a) Have a bachelor's degree from an accredited institution in a human services field
12 and be supervised by:

13 1. A QIDP;

14 2. A registered nurse who has at least two (2) years of experience working with
15 individuals with an intellectual or a development disability;

16 3. An individual with a bachelor's degree in a human service field who has at least
17 two (2) years of experience working with individuals with an intellectual or a
18 developmental disability;

19 4. A qualified social worker who has at least two (2) years of experience working
20 with individuals with an intellectual or a developmental disability;

21 5. A licensed marriage and family therapist who has at least two (2) years of
22 experience working with individuals with an intellectual or a developmental disability;

23 6. A licensed professional clinical counselor who has at least two (2) years of

1 experience working with individuals with an intellectual or a developmental disability;

2 7. A certified psychologist who has at least two (2) years of experience working with
3 individuals with an intellectual or a developmental disability; or

4 8. A licensed psychological practitioner who has at least two (2) years of experience
5 working with individuals with an intellectual or a developmental disability;

6 (b) Be an RN;

7 (c) Be an LPN;

8 (d) Be a qualified social worker;

9 (e) Be an LMFT;'

10 (f) Be an LPCC;

11 (g) Be a certified psychologist; or

12 (h) Be a licensed psychological practitioner.

13 Section 8. Consumer-Directed Option. (1) Covered services and supports provided
14 to a Michelle P. waiver recipient participating in CDO shall be nonmedical and include:

15 (a) A home and community support service which shall:

16 1. Be available only under the consumer-directed option;

17 2. Be provided in the consumer's home or in the community;

18 3. Be based upon therapeutic goals and not diversional in nature;

19 4. Not be provided to an individual if the same or similar service is being provided to
20 the individual via non-CDO Michelle P. waiver services; and

21 5. Include:

22 a. Assistance, support or training in activities including meal preparation, laundry, or
23 routine household care of maintenance;

1 b. Activities of daily living including bathing, eating, dressing, personal hygiene,
2 shopping, or the use of money;

3 c. Reminding, observing, or monitoring of medications;

4 d. Nonmedical care which does not require a nurse or physician intervention;

5 e. Respite; or

6 f. Socialization, relationship building, leisure choice or participation in generic
7 community activities.

8 (b) Goods and services which shall:

9 1. Be individualized;

10 2. Be utilized to reduce the need for personal care or to enhance independence
11 within the home or community of the recipient;

12 3. Not include experimental goods or services; and

13 4. Not include chemical or physical restraints;

14 (c) A community day support service which shall:

15 1. Be available only under the consumer-directed option;

16 2. Be provided in a community setting;

17 3. Be tailored to the consumer's specific personal outcomes related to the
18 acquisition, improvement, and retention of skills and abilities to prepare and support the
19 consumer for work or community activities, socialization, leisure, or retirement activities;

20 4. Be based upon therapeutic goals and not be diversional in nature; and

21 5. Not be provided to an individual if the same or similar service is being provided to
22 the individual via non-CDO Michelle P. waiver services; or

23 (d) Financial management which shall:

- 1 1. Include managing, directing, or dispersing a consumer's funds identified in the
2 consumer's approved CDO budget;
- 3 2. Include payroll processing associated with the individuals hired by a consumer or
4 consumer's representative;
- 5 3. Include withholding local, state, and federal taxes and making payments to
6 appropriate tax authorities on behalf of a consumer;
- 7 4. Be performed by an entity:
 - 8 a. Enrolled as a Medicaid provider in accordance with 907 KAR 1:672; and
 - 9 b. With at least two (2) years of experience working with individuals possessing the
10 same or similar level of care needs as those referenced in Section 5 of this
11 administrative regulation;
- 12 5. Include preparing fiscal accounting and expenditure reports for:
 - 13 a. A consumer or consumer's representative; and
 - 14 b. The department.
- 15 (2) To be covered, a CDO service shall be specified in a plan of care.
- 16 (3) Reimbursement for a CDO service shall not exceed the department's allowed
17 reimbursement for the same or similar service provided in a non-CDO Michelle P waiver
18 setting, except that respite may be provided in excess of the cap established in Section
19 12(2) of this administrative regulation if:
 - 20 (a) Necessary per the consumer's plan of care; and
 - 21 (b) Approved by the department in accordance with subsection (13) of this section.
- 22 (4) A consumer, including a married consumer, shall choose providers and a
23 consumer's choice shall be reflected or documented in the plan of care.

- 1 (5) A consumer may designate a representative to act on the consumer's behalf.
- 2 The CDO representative shall:
- 3 (a) Be twenty-one (21) years of age or older;
- 4 (b) Not be monetarily compensated for acting as the CDO representative or
- 5 providing a CDO service; and
- 6 (c) Be appointed by the consumer on a MAP 2000 form.
- 7 (6) A consumer may voluntarily terminate CDO services by completing a MAP 2000
- 8 and submitting it to the support broker.
- 9 (7) The department shall immediately terminate a consumer from CDO services if:
- 10 (a) Imminent danger to the consumer's health, safety, or welfare exists;
- 11 (b) The consumer fails to pay patient liability;
- 12 (c) The recipient's plan of care indicates he or she requires more hours of service
- 13 than the program can provide; thus, jeopardizing the recipient's safety and welfare due
- 14 to being left alone without a caregiver present; or
- 15 (d) The recipient, caregiver, family, or guardian threaten or intimidate a support
- 16 broker or other CDO staff.
- 17 (8) The department may terminate a consumer from CDO services if it determines
- 18 that the consumer's CDO provider has not adhered to the plan of care.
- 19 (9) Prior to a consumer's termination from CDO services, the support broker shall:
- 20 (a) Notify the assessment or reassessment service provider of potential termination;
- 21 (b) Assist the consumer in developing a resolution and prevention plan;
- 22 (c) Allow at least thirty (30) but no more than ninety (90) days for the consumer to
- 23 resolve the issue, develop and implement a prevention plan, or designate a CDO

1 representative;

2 (d) Complete, and submit to the department, a MAP 2000 terminating the consumer
3 from CDO services if the consumer fails to meet the requirements in paragraph (c) of
4 this subsection; and

5 (e) Assist the consumer in transitioning back to traditional Michelle P. waiver
6 services.

7 (10) Upon an involuntary termination of CDO services, the department shall:

8 (a) Notify a consumer in writing of its decision to terminate the consumer's CDO
9 participation; and

10 (b) Inform the consumer of the right to appeal the department's decision in
11 accordance with Section 13 of this administrative regulation.

12 (11) A CDO provider shall:

13 (a) Be selected by the consumer;

14 (b) Submit a completed Kentucky Consumer Directed Option Employee Provider
15 Contract to the support broker;

16 (c) Be eighteen (18) years of age or older;

17 (d) Be a citizen of the United States with a valid Social Security number or possess
18 a valid work permit if not a U.S. citizen;

19 (e) Be able to communicate effectively with the consumer, consumer representative,
20 or family;

21 (f) Be able to understand and carry out instructions;

22 (g) Be able to keep records as required by the consumer;

23 (h) Submit to a criminal background check;

1 (i) Submit to a check of the nurse aide abuse registry maintained in accordance with
2 906 KAR 1:100 and not be found on the registry;

3 (j) Not have pled guilty or been convicted of committing a sex crime or violent crime
4 as defined in KRS 17.165(1) or (3);

5 (k) Complete training on the reporting of abuse, neglect, or exploitation in
6 accordance with KRS 209.030 or 620.030 and on the needs of the consumer;

7 (l) Be approved by the department;

8 (m) Maintain and submit timesheets documenting hours worked; and

9 (n) Be a friend, spouse, parent, family member, other relative, employee of a
10 provider agency, or other person hired by the consumer.

11 (12) A parent, parents combined, or a spouse shall not provide more than forty (40)
12 hours of services in a calendar week (Sunday through Saturday) regardless of the
13 number of children who receive waiver services.

14 (13)(a) The department shall establish a twelve (12) month budget for a consumer
15 based on the consumer's plan of care.

16 (b) A consumer's twelve (12) month budget shall not exceed \$40,000 unless:

17 1. The consumer's support broker requests a budget adjustment to a level higher
18 than \$40,000; and

19 2. The department approves the adjustment.

20 (c) The department shall consider the following factors in determining whether to
21 grant a twelve (12) month budget adjustment:

22 1. If the proposed services are necessary to prevent imminent institutionalization;

23 2. The cost effectiveness of the proposed services;

1 3. Protection of the consumer's health, safety, and welfare; and

2 4. If a significant change has occurred in the recipient's:

3 a. Physical condition, resulting in additional loss of function or limitations to activities
4 of daily living and instrumental activities of daily living;

5 b. Natural support system; or

6 c. Environmental living arrangement, resulting in the recipient's relocation.

7 (d) A consumer's twelve (12) month budget may encompass a service or any
8 combination of services listed in subsection (1) of this section, if each service is
9 established in the consumer's plan of care and approved by the department.

10 (14) Unless approved by the department pursuant to subsection (13)(a) through (c)
11 of this section, if a CDO service is expanded to a point in which expansion necessitates
12 a twelve (12) month budget increase, the entire service shall only be covered via
13 traditional (non-CDO) waiver services.

14 (15) A support broker shall:

15 (a) Provide needed assistance to a consumer with any aspect of CDO or blended
16 services;

17 (b) Be available to a consumer twenty-four (24) hours per day, seven (7) days per
18 week;

19 (c) Comply with all applicable federal and state laws and requirements;

20 (d) Continually monitor a consumer's health, safety, and welfare; and

21 (e) Complete or revise a plan of care using person-centered planning principles.

22 (16)(a) A support broker or case manager may conduct an assessment or
23 reassessment for a CDO participant; and

1 (b) A CDO assessment or reassessment performed by a support broker shall
2 comply with the assessment or reassessment provisions established in this
3 administrative regulation.

4 Section 9. Annual Expenditure Limit Per Individual. (1) The department shall have
5 an annual expenditure limit per individual receiving services via this administrative
6 regulation.

7 (2) The limit referenced in subsection (1) of this section shall:

8 (a) Be an overall limit applied to all services whether CDO services, Michelle P.
9 waiver services not provided via CDO, or a combination of CDO and Michelle P. waiver
10 services; and

11 (b) Shall equal \$63,000 per year.

12 Section 10. Incident Reporting Process. (1) An incident shall be documented on an
13 incident report form.

14 (2) There shall be three (3) classes of incidents including:

15 (a) A class I incident which shall:

- 16 1. Be minor in nature and not create a serious consequence;
- 17 2. Not require an investigation by the provider agency;
- 18 3. Be reported to the case manager or support broker within twenty-four (24) hours;
- 19 4. Be reported to the guardian as directed by the guardian; and
- 20 5. Be retained on file at the provider and case management or support brokerage
21 agency.

22 (b) A class II incident which shall:

- 23 1. Be serious in nature;

- 1 2. Involve the use of physical or chemical restraints;
- 2 3. Require an investigation which shall be initiated by the provider agency within
- 3 twenty-four (24) hours of discovery;
- 4 4. Be reported by the provider agency to:
- 5 a. The case manager or support broker within twenty-four (24) hours;
- 6 b. The guardian within twenty-four (24) hours;
- 7 c. The department within ten (10) calendar days of discovery, and shall include a
- 8 complete written report of the incident investigation and follow up; and
- 9 (c) A class III incident which shall:
- 10 1.a. Be grave in nature;
- 11 b. Involve suspected abuse, neglect, or exploitation;
- 12 c. Involve a medication error which requires a medical intervention; or
- 13 d. Be a death.
- 14 2. Be immediately investigated by the provider agency, and the investigation shall
- 15 involve the case manager or support broker; and
- 16 3. Be reported by the provider agency to:
- 17 a. The case manager or support broker within eight (8) hours of discovery;
- 18 b. DCBS immediately upon discovery, if involving suspected abuse, neglect, or
- 19 exploitation in accordance with KRS Chapter 209 or 620.030;
- 20 c. The guardian within eight (8) hours of discovery; and
- 21 d. The department within eight (8) hours of discovery and shall include a complete
- 22 written report of the incident investigation and follow-up within seven (7) calendar days
- 23 of discovery. If an incident occurs after 5 p.m. on a weekday or occurs on a weekend or

1 holiday, notification to the department shall occur on the following business day.

2 (3) Documentation with a complete written report for a death shall include:

3 (a) The recipient's current plan of care;

4 (b) The recipient's current list of prescribed medications including pro re nata (PRN)
5 medications;

6 (c) The recipient's current crisis plan;

7 (d) Medication administration review forms for the current and previous month;

8 (e) Staff notes from the current and previous month including details of physician
9 and emergency room visits;

10 (f) Any additional information requested by the department necessary to determine if
11 a corrective action needs to be taken by the Cabinet for Health and Family Services
12 against the provider;

13 (g) A coroner's report when received; and

14 (h) If performed, an autopsy report when received.

15 (4) All medication errors shall be reported to the department on a Michelle P. Waiver
16 Medication Error Report by the 15th of the following month.

17 Section 11. Michelle P. Waiver Program Waiting List. (1)(a) If a slot is not available
18 for an individual to enroll in the Michelle P. Waiver Program at the time of applying for
19 the program, the individual shall be placed on a statewide Michelle P. Waiver Program
20 waiting list:

21 1. In accordance with subsection (2) of this section; and

22 2. Which shall be maintained by the department.

23 (b) Each slot for the Michelle P. Waiver Program shall be contingent upon:

1 1. Biennium budget funding;
2 2. Federal financial participation; and
3 3. Centers for Medicare and Medicaid Services approval.
4 (2) For an individual to be placed on the Michelle P. Waiver Program waiting list,
5 the:
6 (a) Individual shall submit to the department a completed Application for MPW
7 Services; and
8 (b)1. Department shall place the individual on the waiting list if the department
9 confirms that the MAP-621, Application for MPW Services, has been correctly
10 completed.
11 2. If the department determines that a MAP-621, Application for MPW Services, has
12 not been completed correctly, the department shall return the form to the applicant
13 notifying the applicant of the incorrectness or missing information.
14 (3) Individuals shall be placed on the Michelle P. Waiver Program waiting list in the
15 chronological order that the application is received and validated by the department.
16 (4) The department shall send a written notice of placement on the Michelle P.
17 Waiver Program waiting list to the:
18 (a) Applicant; or
19 (b) Applicant's legal representative.
20 (5) At least annually, the department shall contact each individual, or individual's
21 legal representative, on the Michelle P. Waiver Program waiting list to:
22 (a) Verify the accuracy of the individual's information; and
23 (b) Verify whether the individual wishes to continue to pursue enrollment in the

1 Michelle P. Waiver Program.

2 (6) The department shall remove an individual from the Michelle P. Waiver Program
3 waiting list if:

4 (a) After a documented attempt, the department is unable to contact or locate the
5 individual or the individual's legal representative;

6 (b) The individual is deceased; or

7 (c) The department notifies the individual or the individual's legal representative of
8 potential funding approved to enroll the individual in the Michelle P. Waiver Program
9 and the individual or individual's legal representative:

10 1. Declines the potential funding for enrollment in the program; and

11 2. Does not request to remain on the Michelle P. Waiver Program waiting list.

12 (7) If, after being notified by the department of potential funding approved to enroll
13 the individual in the Michelle P. Waiver Program, the individual or individual's legal
14 representative declines the potential funding but requests to remain on the Michelle P.
15 Waiver Program waiting list, the individual shall:

16 (a) Lose his or her current position on the waiting list; and

17 (b) Be moved to the bottom of the waiting list.

18 (8) If the department removes an individual from the Michelle P. Waiver Program
19 waiting list pursuant to this section, the department shall send written notice of the
20 removal to:

21 (a) The individual or the individual's legal representative; and

22 (b) The individual's Michelle P. Waiver Program coordination provider if the
23 individual has a Michelle P. Waiver Program coordination provider.

1 (9) The removal of an individual from the Michelle P. Waiver Program waiting list
2 shall not preclude the individual from applying for Michelle P. Waiver Program
3 participation in the future.

4 **(10) An individual who is:**

5 **(a) At least twenty-one (21) years of age and who is placed on the Michelle P.**
6 **Waiver Program waiting list shall be informed about and told how to apply for**
7 **Medicaid state plan services for which the individual might qualify; or**

8 **(b) Under twenty-one (21) years of age and who is placed on the Michelle P.**
9 **Waiver Program waiting list shall be informed about:**

10 **1. And told how to apply for Medicaid state plan services for which the**
11 **individual might qualify; and**

12 **2. Early and Periodic Screening, Diagnostic, and Treatment services.**

13 Section 12. Use of Electronic Signatures. (1) The creation, transmission, storage,
14 and other use of electronic signatures and documents shall comply with the
15 requirements established in KRS 369.101 to 369.120.

16 (2) A home health provider that chooses to use electronic signatures shall:

17 (a) Develop and implement a written security policy that shall:

18 1. Be adhered to by each of the provider's employees, officers, agents, and
19 contractors;

20 2. Identify each electronic signature for which an individual has access; and

21 3. Ensure that each electronic signature is created, transmitted, and stored in a
22 secure fashion;

23 (b) Develop a consent form that shall:

- 1 1. Be completed and executed by each individual using an electronic signature;
- 2 2. Attest to the signature's authenticity; and
- 3 3. Include a statement indicating that the individual has been notified of his or her
- 4 responsibility in allowing the use of the electronic signature; and

5 (c) Provide the department with:

- 6 1. A copy of the provider's electronic signature policy;
- 7 2. The signed consent form; and
- 8 3. The original filed signature immediately upon request.

9 Section 13.~~[12.]~~ Reimbursement. (1) The following Michelle P. waiver services,
10 alone or in any combination, shall be limited to forty (40) hours per calendar week:

- 11 (a) Homemaker;
 - 12 (b) Personal care;
 - 13 (c) Attendant care;
 - 14 (d) Supported employment;
 - 15 (e) Adult day health care;
 - 16 (f) Adult day training;
 - 17 (g) Community living supports;
 - 18 (h) Physical therapy;
 - 19 (i) Occupational therapy;
 - 20 (j) Speech therapy; and
 - 21 (k) Behavior supports.
- 22 (2) Respite services shall not exceed \$4,000 per member, per calendar year.
- 23 (3) Environmental and minor home adaptation services shall not exceed \$500 per

1 member, per calendar year.

2 (4)(a) The department shall reimburse for a Michelle P. waiver service at the lesser
3 of billed charges or the fixed upper payment rate for each unit of service.

4 (b) The following rates shall be the fixed upper payment rate limits:

Service	Fixed Upper Payment Rate Limit	Unit of Service
Case Management	\$50.00	15 minutes
Respite	\$4,000 per calendar year	15 minutes
Homemaker	\$6.50	15 minutes
Personal Care	\$7.50	15 minutes
Attendant Care	\$2.90	15 minutes
Supported Employment	\$5.54	15 minutes
Adult Day Health Care	\$2.75	15 minutes
Adult Day Training	\$2.75	15 minutes
Community Living Supports	\$5.54	15 minutes
Physical Therapy	\$22.17	15 minutes
Occupational Therapy	\$22.17	15 minutes
Speech Therapy	\$22.17	15 minutes
Behavior Supports	\$33.25	15 minutes
Environmental and Minor Home Adaptation	\$500 per calendar year	
Financial Management	\$12.50 (not to exceed eight	15 minutes

	(8) units or \$100.00 per month)	
Support Broker	\$265.00	One (1) month

1 Section 14. Federal Financial Participation and Approval. The department's
2 coverage and reimbursement for services pursuant to this administrative regulation
3 shall be contingent upon:

4 (1) Receipt of federal financial participation for the coverage and reimbursement;

5 and

6 (2) Centers for Medicare and Medicaid Services' approval of the coverage and
7 reimbursement.

8 Section 15.[13.] Appeal Rights. An appeal of a department determination regarding
9 Michelle P. waiver service level of care or services to a Michelle P. waiver recipient or a
10 consumer shall be in accordance with 907 KAR 1:563.

11 Section 16.[14.] Incorporation by Reference. (1) The following material is
12 incorporated by reference:

13 (a) "Person Centered Planning: Guiding Principles", March 2005[~~edition~~];

14 (b) "MAP-24, The Commonwealth of Kentucky, Cabinet for Health and Family
15 Services, Department for Community Based Services Memorandum", **August**
16 **2008**[~~February 2001~~]-[~~edition~~];

17 (c)[~~(f)~~] "MAP-95 Request for Equipment Form", June 2007[~~edition~~];

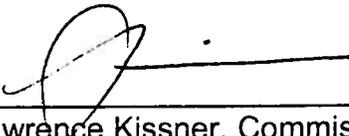
18 (d)[~~(g)~~] "MAP 109, Plan of Care/Prior Authorization for Waiver Services", **July**
19 **2008**[~~March 2007~~]-[~~edition~~];

1 (e)[(h)] "MAP-350, Long Term Care Facilities and Home and Community Based
2 Program Certification Form", July 2008~~[January 2000]~~[-edition];
3 (f)[(i)] "MAP-351, The Department for Medicaid Services, Medicaid Waiver
4 Assessment", July 2008~~[March 2007]~~[-edition];
5 (g)[(j)] "MAP 2000, Initiation/Termination of Consumer Directed Option (CDO)", July
6 2008~~[March 2007]~~[-edition];
7 (h)[(k)] "MAP-10, Waiver Services", August 2014~~[March 2007]~~[-edition];
8 (i)[(l)] "The Kentucky Consumer Directed Option Employee Provider Contract",
9 August 2010~~[May 4, 2007]~~[-edition];
10 (j)[(m)] "Michelle P. Waiver Incident Report Form", May 2013~~[April 2, 2007]~~
11 ~~edition~~; and~~[and]~~
12 (k)[(n)] [~~"Michelle P. Waiver Medication Error Report", November 19, 2008; and~~
13 ~~(l)~~] "MAP-621, Michelle P. Waiver Application Form", January 2014[-edition].
14 (2) This material may be inspected, copied, or obtained, subject to applicable
15 copyright law, at the Department for Medicaid Services, 275 East Main Street,
16 Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (35 Ky.R. 688;
17 Am. 1493; 1804; 1974; eff. 2-6-2009; TAm 7-16-2013.)

907 KAR 1:835

REVIEWED:

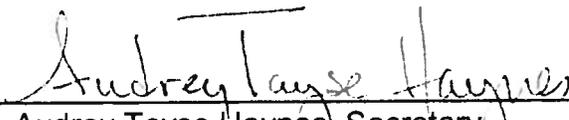
7/28/14
Date



Lawrence Kissner, Commissioner
Department for Medicaid Services

APPROVED:

8/7/14
Date



Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 1:835
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact: Stuart Owen (502) 564-4321

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation establishes the Department for Medicaid Services' (DMS's) coverage and reimbursement provisions requirements regarding Michelle P. Waiver (MPW) Program services. The Michelle P. Waiver Program is a program which enables individuals who have care needs that qualify them for receiving services in an intermediate care facility for individuals with an intellectual disability (ICF IID) to reside in and receive services in a community setting rather than in an institutional setting.
 - (b) The necessity of this administrative regulation: The administrative regulation is necessary to establish DMS's coverage and reimbursement provisions and requirements regarding MPW services.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: The administrative regulation conforms to the content of the authorizing statutes by establishing DMS's coverage and reimbursement provisions and requirements regarding MPW services.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing DMS's coverage and reimbursement provisions and requirements regarding MPW Program services.

- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
 - (a) How the amendment will change this existing administrative regulation: The amendment establishes that the number of Michelle P. Waiver Program participants shall not exceed the limited established by the Centers for Medicare and Medicaid Services (CMS); creates a waiting list for individuals applying to receive Michelle P. Waiver Program services along with provisions and requirements regarding the waiting list. The amendment after comments deletes the definition of "certified psychologist with autonomous functioning"; inserts a definition for "licensed psychologist"; inserts a definition for "licensed psychological practitioner"; deletes the requirement that respite care notes address the progression, regression, and maintenance toward outcomes in the recipient's plan of care; deletes the requirement that notes regarding an environmental and minor home adaptation address the progression, regression, and maintenance toward outcomes in the recipient's plan of care; and inserts a requirement that when individuals are placed on the MPW waiting list that they be informed about Medicaid state plan

- services and, if under twenty-one (21), of early and periodic screening, diagnostic, and treatment (EPSDT) services.
- (b) The necessity of the amendment to this administrative regulation: The amendment is necessary to ensure that DMS receives federal funding associated with the expenditures for every individual who receives Michelle P. Waiver Program services and to ensure DMS compliance with the requirements established for the program by the federal agency (CMS) which provides funding for and authorizes the program. The amendments after comments regarding the respective definitions of certified psychologist with autonomous functioning, licensed psychologist, and licensed psychological practitioner are necessary to synchronize the regulation with the relevant Kentucky Revised Statutes. Deleting the requirements regarding notes is necessary as those requirements are not applicable to respite care or environmental and minor home adaptations. Adding the requirement that individuals on the waiting list be informed of other services is necessary to heighten awareness of other options to receive services.
 - (c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by ensuring that this Medicaid waiver program is approved by the federal government and funded with federal funds. The amendments after comments conform to the content of the authorizing statutes by synchronizing definitions with the applicable Kentucky Revised Statutes; by eliminating erroneous requirements; and by enhancing recipient awareness of other services.
 - (d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by ensuring that this Medicaid waiver program is approved by the federal government and funded with federal funds. The amendments after comments will assist in the effective administration of the authorizing statutes by synchronizing definitions with the applicable Kentucky Revised Statutes; by eliminating erroneous requirements; and by enhancing recipient awareness of other services.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: There are currently 284 providers participating in the Michelle P. Waiver Program and over 9,500 individuals receiving services via the program. DMS estimates that the number of individuals who could currently qualify to be placed on the program's waiting list could be 283.
- (4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
- (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Individuals (or legal representatives of individuals) who wish to be placed on the Michelle P. Waiver Program waiting list will need to complete an application form and submit it to DMS.

- (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). The amendment imposes no cost.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Individuals who wish to receive Michelle P. Waiver Program services will benefit from the presence of a waiting list which designates the individual's specific place on the list rather than having to apply and continually reapply with no guarantee of having a spot in line.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
- (a) Initially: The amendment is not expected to increase Medicaid Program costs. The 2013 calendar year costs for the Michelle P. Waiver program was \$213, 632, 087 (federal and state funds combined.)
 - (b) On a continuing basis: The amendment is not expected to increase Medicaid Program costs on a continuing basis.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Federal funds authorized under the Social Security Act, Title XIX and state matching funds from general fund and restricted fund appropriations are utilized to fund the this administrative regulation.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding is necessary to implement the amendment.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment neither establishes nor increases any fees.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used.) Tiering is not applied as the amendment applies equally to all regulated entities/individuals.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 1:835

Agency Contact Person: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation.
2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation authorizes the action taken by this administrative regulation.
3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
 - (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The amendment is not anticipated to generate a higher level of revenues for state or local government.
 - (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The response in (a) above also applies here.
 - (c) How much will it cost to administer this program for the first year? The amendment is not expected to increase Medicaid program costs.
 - (d) How much will it cost to administer this program for subsequent years? The response in (c) above also applies here.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:835, Michelle P. Waiver Services
and Reimbursement

Summary of Material Incorporated by Reference
Amended After Comments

(1) The following material is incorporated by reference:

(a) "Person Centered Planning: Guiding Principles", March 2005 which is a two (2) page form used in developing an individual's plan of care.

(b) "MAP-24, The Commonwealth of Kentucky, Cabinet for Health and Family Services, Department for Community Based Services Memorandum", August 2008 is replacing the February 2001 as the newer version was reformatted. The form is used to denote when an individual is admitted to or discharged from a facility or the waiver program. The newer form - a one (1) page form - adds an option to indicate if the recipient was discharged or admitted rather than only having the discharge denotation option. The newer form also added the Michelle P. Waiver as an option.

(c) "MAP-95 Request for Equipment Form", June 2007 which is a one (1) page form used when equipment is requested for a Michelle P. Waiver program recipient.

(d) "MAP-109, Plan of Care/Prior Authorization for Waiver Services", July 2008 is replacing the March 2007 as the newer version was reformatted and now includes a box in which to denote the Michelle P. Waiver as an option. This is a five (5) page form.

(e) "MAP-350, Long Term Care Facilities and Home and Community Based Program Certification Form", July 2008 is replacing the January 2000 as the newer version was reformatted. This newer form - a two (2) page form - contains an option for the recipient or recipient's legal representative to denote whether or not they are requesting Michelle P. Waiver program services.

(f) "MAP-351, The Department for Medicaid Services, Medicaid Waiver Assessment", July 2008 fifteen (15) page form is replacing the March 2007 as the newer version adds the Michelle P. Waiver as an option. This form is used to assess individuals' needs as they relate to the Michelle P. Waiver program.

(g) "MAP-2000, Initiation/Termination of Consumer Directed Option (CDO)", July 2008 is replacing the March 2007 as the newer version adds "MP" (Michelle P. Waiver) as an option. This is a two (2) page form and is used whenever an individual begins receiving CDO services or stops receiving CDO services.

(h) "MAP-10, Waiver Services Physician's Recommendation", August 2014 is replacing the March 2007 as the title of this one (1) page form was amended and the ABI waiver and Michelle P. Waiver were added to the boxes of waiver options. Also the request for the physician's UPIN number was deleted as this number is no longer required. This form documents the recommendation made by a physician that the individual needs Michelle P. Waiver services.

(i) "Kentucky Consumer Directed Option Employee Provider Contract", August 2010 replaces the May 4, 2007. This two (2) page form is used when an individual opts to use consumer directed option (CDO) services and hires someone to provide a given CDO service. The form has been revised to insert an option to designate the Michelle P. Waiver as well as an option to designate the Money Follows the Person program.

(j) The "Michelle P. Waiver Incident Report Form", May 2013 is replacing the April 2, 2007 as the title has been revised to customize it for the Michelle P. Waiver program. This is a two (2) page form and is used to document incidents (health/safety related incidents for example.)

(2) The "Michelle. P. Waiver Medication Error Report", November 19, 2008 is being removed from the incorporated material as it is not used.

(3) A total of thirty three (33) pages are incorporated by reference.

STATEMENT OF CONSIDERATION RELATING TO
907 KAR 1:835

Department for Medicaid Services
Amended After Comments

(1) A public hearing regarding 907 KAR 1:835 was not requested and; therefore, not held.

(2) The following individuals submitted written comments regarding 907 KAR 1:835:

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Steve Shannon, Executive Director	Kentucky Association of Regional Mental Health & Mental Retardation Programs, Inc. (KARP)
Johnny Callebs, First Vice President of Public Policy	Kentucky Association of Private Providers (KAPP)
William S. Dolan, Staff Attorney Supervisor	Protection & Advocacy (P&A)
Lisa Willner, Ph.D., Executive Director	Kentucky Psychological Association

(3) The following individuals from the promulgating agency responded to comments received regarding 907 KAR 1:835:

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Stuart Owen, Regulation Coordinator	Department for Medicaid Services
Sheila Davis, Manager	Department for Medicaid Services, Division of Community Alternatives, Mental Health/Intellectual and Developmental Disabilities Branch

SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Psychologist-Related Definitions

(a) Comment: Lisa Willner, Executive Director, Kentucky Psychological Association, stated:

"Section 1(9) Definition of "'Certified psychologist with autonomous functioning' or licensed 'psychological practitioner'

Comment: “The terminology that has historically been used in this regulation regarding the Michelle P. Waiver program does not accurately reflect the titles of psychological providers who are licensed by the Kentucky Board of Examiners of psychology to independently provide psychological services in the Commonwealth. One group are professionals who have a doctoral degree and are licensed under KRS 319.050. Their title which is not referenced in the current regulation, is ‘Licensed Psychologist.’

The other groups are professionals who have a Master’s degree and who are licensed under KRS 319.053 and KRS 319.056 to practice psychology at an independent (unsupervised) level. They have the title: ‘Certified Psychologist with Autonomous Functioning’ or the title ‘Licensed Psychological Practitioner’.

We request that 907 KAR 1:835 be amended to correct the title references in the current regulation to bring them into compliance with the statute, as noted in the Addendum at the end of this letter. Also, KRS 319 was revised by the 2010 KY General Assembly, and the term ‘psychologist’ is not defined in KRS 319.010(9), not (8).

We request that this be done by deleting (9) and (38)[(37)] in Section 1 and inserting the bold, underlined language below in Section 1, (37) [(36)]:

In Section 1. Definitions

Delete (9) ‘Certified psychologist...’

In (37) [(36)] Revise the language as: ‘Psychologist’ is defined by KRS 319.010 ~~(9)~~[(8)] **and includes ‘Licensed psychologist’ definition in KRS 319.050; ‘Certified psychologist with autonomous functioning defined in KRS 319.053; and ‘Licensed psychological practitioner defined in KRS 319.056;**

Delete (38)[(37)] ‘psychological with autonomous...’”

(b) Response: Via an “amended after comments” administrative regulation the Department for Medicaid Services (DMS) is deleting the definition for “psychologist with autonomous functioning and is inserted the following definitions of “licensed psychologist” and “licensed psychological practitioner” respectively:

“(26) “Licensed psychologist” means an individual who:

(a) Currently possesses a licensed psychologist licensed in accordance with KRS 319.010(6); and

(b) Meets the licensed psychologist requirements established in 201 KAR Chapter 26.

(27) “Licensed psychological practitioner” means an individual who:

(a) Meets the requirements established in KRS 319.053; or

(b) Is a certified psychologist with autonomous functioning.”

(2) Subject: Enrollment

(a) Comment: William S. Nolan, Staff Attorney Supervisor, Protection and Advocacy stated:

“Comment: Will those individuals who meet the urgent SCL category of need (907 KAR 1:145, 7 (7)(b) now 907 KAR 12:010, 7 (5)(b)) still maintain first priority enrollment for Michelle P.?”

(b) Response: Unlike the SCL Waiver Program waiting list there are no categories of need for the Michelle P. Waiver Program waiting list.

(3) Subject: Notice of Other Services

(a) Comment: William S. Nolan, Staff Attorney Supervisor, Protection and Advocacy commented:

“Section 11. Michelle P. Program Waiting List

Comment: “We recommend adding the following as the cabinet has a federal duty to inform those eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services about EPSDT. Many individuals who apply for Michelle P. will be under the age of 21 and possibly EPSDT eligible. See 42 U.S.C. 1396a(a)(43)(A) (a State Medicaid plan must provide for informing those under 21 about the availability of EPSDT services).”

(10) An individual who is placed on the Michelle P. waiting list shall be informed about and told how to apply for other Medicaid services for which he or she might qualify including but not limited to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.”

(b) Response: Via an “amended after comments” administrative regulation DMS is adding the following language:

“(10) An individual who is:

(a) At least twenty-one (21) years of age and who is placed on the Michelle P. Waiver Program waiting list shall be informed about and told how to apply for Medicaid state plan services for which the individual might qualify; or

(b) Under twenty-one (21) years of age and who is placed on the Michelle P. Waiver Program waiting list shall be informed about:

1. And told how to apply for Medicaid state plan services for which the individual might qualify; and

2. Early and Periodic Screening, Diagnostic, and Treatment services.”

As explanation, the Legislative Research Commission prohibits the use of the phrase “including but not limited to” in administrative regulation as it is considered “ambiguous” which violates administrative regulation drafting requirements pursuant to KRS

13A.222(4).

(4) Subject: Conflict Free Case Management

(a) Comment: Steve Shannon, Executive Director of KARP, stated:

“Comment: It is the understanding of KARP and its eleven member CMHC that the Michelle P. regulation will go through another revision and corresponding public comment period. The proposed revisions may results in the Michelle P. waiver services being more consistent with the SCL II waiver services as outlined in 907 KAR 12:010. A primary concern which was not addressed in the current proposed changes to the Michelle P. waiver regulation are the case management and supported employment rates. It was our understanding that the Michelle P. case management and supported employment rates would be increased to match the SCL case management rate of \$320 per month and the SCL supported employment rates of \$10.25 per on quarter hour unit.

It is recommended the following language be added to Section 7. (1) (c) 8.

8. An exemption to the conflict free requirement shall be granted if:

a. A participant requests the exemption; and

b. The participant’s case manager provides documentation to DBHDID:

a. Provides evidence that there is a lack of a qualified case manager within thirty (30) miles of the participant’s residence; or

b. There is a relationship between the participant and the participant’s case manager.

c. A request to receive a case management service that is not conflict free shall accompany each prior authorization request for the case management service.

The proposed language will result in individuals who are participating in the Michelle P. waiver being treated equitably with individuals who are participating in the SCL waiver in terms of access to case management services. Both waivers will enable individuals to request an exemption to conflict free case management based upon either geographical proximity or established relationship with a case manager.

The implementation of a waiting list for Michelle P. services will result in more individuals accessing supports through state general fund dollars distributed by the Department of Behavioral Health and Developmental and Intellectual Disabilities Services. As the individuals on the waiting list gain access to Michelle P. waiver services, they should not be forced to discontinue case management relationships solely due to access a new funding source.”

Therefore, it is recommended the case management exemption protocol delineated in 907 KAR 12:020 be applied to Michelle P. waiver case management services.”

(b) Response: DMS inserted an exception to the conflict free requirement during the initial implementation of the Michelle P. Waiver program (2008) and sunset the

exception on January 1, 2011. The exception, as endorsed by the Administrative Regulation Review Subcommittee at the time, was established to grant providers and recipients a transition time (temporary in nature) to arrange case management in a conflict free manner as required by the Centers for Medicare and Medicaid Services (CMS).

CMS has established a conflict free case management requirement and DMS is not aware that CMS is relaxing the requirement.

Additionally, DMS is currently performing a thorough review of all of its 1915(c) home and community based waiver programs to determine the changes needed to comply with a rule that the Centers for the Medicare and Medicaid Services (CMS) issued earlier this year regarding these programs. DMS is also trying to determine the amount of increased costs DMS will experience associated with complying with the rule.

DMS's preliminary belief is that compliance will increase DMS's expenditures significantly and DMS is facing a substantial budget deficit for the current state fiscal year.

Each state has five (5) years to bring each 1915(c) home and community based waiver program into compliance with the new rule. The requested change would necessitate an amendment to the corresponding 1915(c) home and community based services waiver. Submitting an amendment to the waiver would expose the entire waiver to coercion from CMS (who reviews waivers and waiver amendments and decides whether or not to approve them and to provide federal funds) to bring the waiver in full compliance with the requirements in the HCBS rule issued by CMS earlier this year. DMS does not intend to submit any such waiver amendments to CMS this year nor make any substantive changes to the administrative regulation.

(c) Comment: Johnny Callebs, First Vice President of Public Policy, KAPP, stated:

“Page 17 – Section 7 (3)(b) Currently in the Michelle P. Waiver, the Community Mental Health Centers use the MAP 351 as an assessment to determine eligibility for the waiver. Within a year, the waiver recipient has to be reassessed for eligibility by the Community Mental Health Centers using the MAP 351. In the Supports for Community Living waiver program, Case Managers have been responsible for completing the MAP 351 for years and sending it to Carewise to determine eligibility. The waiver recipient's Case Manager meets the same academic requirements as the assessors from the Community Mental Health Centers who do the reassessments annually. We recommend after the initial assessment has been completed by the Community Mental Health Centers that the recipient's Case Manager be responsible for completing the annual reassessment for eligibility of services.”

(d) Response: DMS is currently performing a thorough review of all of its 1915(c) home and community based waiver programs to determine the changes needed to comply with a rule that the Centers for the Medicare and Medicaid Services (CMS) issued

earlier this year regarding these programs. DMS is also trying to determine the amount of increased costs DMS will experience associated with complying with the rule.

DMS's preliminary belief is that compliance will increase DMS's expenditures significantly and DMS is facing a substantial budget deficit for the current state fiscal year.

Each state has five (5) years to bring each 1915(c) home and community based waiver program into compliance with the new rule. The requested change would necessitate an amendment to the corresponding 1915(c) home and community based services waiver. Submitting an amendment to the waiver would expose the entire waiver to coercion from CMS (who reviews waivers and waiver amendments and decides whether or not to approve them and to provide federal funds) to bring the waiver in full compliance with the requirements in the HCBS rule issued by CMS earlier this year. DMS does not intend to submit any such waiver amendments to CMS this year nor make any substantive changes to the administrative regulation.

(e) Comment: Johnny Callebs, First Vice President of Public Policy, KAPP, stated:

“Page 18 – Section 7 (3) (c)2b – “Contact the Michelle P. waiver recipient monthly through a face-to-face visit at the Michelle P. recipient’s home, in the ADHC center, or the adult day training provider’s location.” Currently, Case Managers can only conduct a face-to-face visit in these three sites. This requirement contradicts a central premise of the waiver which is for recipients to receive services in a community setting. A large contingency of Michelle P waiver recipients are children who do not meet the age requirements to attend Adult Day Health Care (ADHC) and ADT centers. As such, the Case Manager can only go to the house to have a face. Sometimes, the requirement of the face-to-face visit only being in the home interrupts the service of Community Living Supports (CLS) because the waiver recipient has to physically be back in the home. We recommend removing restrictions on where the face-to-face visits occur and allow Case Managers the freedom to effectively monitor services where they occur.”

(f) Response: DMS is not making any substantive changes to the administrative regulation at this time as explained in response (d) above.

(g) Comment: Johnny Callebs, First Vice President of Public Policy, KAPP, stated:

“Page 18 – Section 7 (3) (c) 3 – “shall not include a group conference”. Is this not the same thing as a Person Centered Support Team meeting? Please define group conference or delete it from the regulation.”

(h) Response: DMS is not making any substantive changes to the administrative regulation at this time as explained in response (d) above.

(i) Comment: Johnny Callebs, First Vice President of Public Policy, KAPP, stated:

“Page 19 – Section 7 (3) (c) 5.b. – ‘Progression, regression, and maintenance toward outcomes identified in the plan of care.’ In order for case managers to identify progression, regression, and maintenance toward outcomes in their monthly summary notes, they must review the monthly summaries from the service providers. Usually case managers just end up restating what was written by the service providers. We recommend this part of the regulation be changed to require the case manager to monitor and summarize the effectiveness of the individual services listed on the Plan of Care.”

(j) Response: The case manager is responsible for overseeing the monthly notes to ensure that services are being provided. The case manager must summarize the effectiveness of the services by documenting progression, regression, and maintenance toward outcomes in order to ensure that services are being provided.

(k) Comment: Johnny Callebs, First Vice President of Public Policy, KAPP, stated:

“Pages 19-20 – Section 7 (3) (c) 7. We recommend that there be an exception process to allow a recipient to keep his/her case manager even if the case management agency also provides a service to the recipient. To promote uniformity across waivers, the exception process should be the same as in 907 KAR 12:010.”

(l) Response: DMS inserted an exception to the conflict free requirement during the initial implementation of the Michelle P. Waiver program (2008) and sunset the exception on January 1, 2011. The exception, as endorsed by the Administrative Regulation Review Subcommittee at the time, was established to grant providers and recipients a transition time (temporary in nature) to arrange case management in a conflict free manner as required by the Centers for Medicare and Medicaid Services (CMS).

CMS has established a conflict free case management requirement and DMS is not aware that CMS is relaxing the requirement.

Additionally, DMS is currently performing a thorough review of all of its 1915(c) home and community based waiver programs to determine the changes needed to comply with a rule that the Centers for the Medicare and Medicaid Services (CMS) issued earlier this year regarding these programs. DMS is also trying to determine the amount of increased costs DMS will experience associated with complying with the rule.

DMS's preliminary belief is that compliance will increase DMS's expenditures significantly and DMS is facing a substantial budget deficit for the current state fiscal year.

Each state has five (5) years to bring each 1915(c) home and community based waiver program into compliance with the new rule. The requested change would necessitate an amendment to the corresponding 1915(c) home and community based services waiver. Submitting an amendment to the waiver would expose the entire waiver to coercion

from CMS (who reviews waivers and waiver amendments and decides whether or not to approve them and to provide federal funds) to bring the waiver in full compliance with the requirements in the HCBS rule issued by CMS earlier this year. DMS does not intend to submit any such waiver amendments to CMS this year nor make any substantive changes to the administrative regulation.

(5) Subject: Suggested Removal of Requirements Regarding Notes

(a) Comment: Johnny Callebs, First Vice President of Public Policy, KAPP, stated:

“Page 22 – Section 7 (3) (g) 5.b. – Respite is for relief of the primary caretaker and should not require a note that identifies progression, regression, and maintenance toward outcomes identified in the Plan of Care. Please remove the requirement for identifying progression, regression, and maintenance.”

(b) Response: DMS agrees as this requirement was mistakenly inserted. DMS is removing the requirement via an “amended after comments” administrative regulation.

(c) Comment: Johnny Callebs, First Vice President of Public Policy, KAPP, stated:

“Page 23 – Section 7 (3) (h) – An environmental and minor home adaptation service should not require a note detailing progression, regression, and maintenance toward outcomes identified in the Plan of Care. Typically, this is a one-time service during the plan of care year. We recommend deleting the note requirement and replacing it with documentation requirements listed in 907 KAR 12:010 for an environmental accessibility adaption service.”

(d) Response: DMS agrees as this requirement was mistakenly inserted. DMS is removing the requirement via an “amended after comments” administrative regulation.

(11) Subject: Adult day training suggestions in Michelle P. Waiver

(a) Comment: Johnny Callebs, First Vice President of Public Policy, KAPP, stated:

“Page 27 – Section 7 (3) (l)8 – Require that an adult day training service provider conduct, at least annually, an orientation informing the recipient of supported employment and other competitive opportunities in the community.” Since the Michelle P. Waiver regulations were originally written, there has been an increase in agencies providing supported employment services, many of which are not tied to adult day training centers. Likewise, there are adult day training providers who do not provide supported employment services. Some agencies provide both. To further promote freedom of choice, we recommend that the annual orientation on supported employment be done during the plan of care meeting and not made the obligation of the adult day training provider and that the recipient be allowed to opt out of the annual orientation if he/she makes it clear to the support team that it is not a service he/she wants.”

(b) Response: DMS is currently performing a thorough review of all of its 1915(c) home and community based waiver programs to determine the changes needed to comply with a rule that the Centers for the Medicare and Medicaid Services (CMS) issued earlier this year regarding these programs. DMS is also trying to determine the amount of increased costs DMS will experience associated with complying with the rule.

DMS's preliminary belief is that compliance will increase DMS's expenditures significantly and DMS is facing a substantial budget deficit for the current state fiscal year.

Each state has five (5) years to bring each 1915(c) home and community based waiver program into compliance with the new rule. The requested change would necessitate an amendment to the corresponding 1915(c) home and community based services waiver. Submitting an amendment to the waiver would expose the entire waiver to coercion from CMS (who reviews waivers and waiver amendments and decides whether or not to approve them and to provide federal funds) to bring the waiver in full compliance with the requirements in the HCBS rule issued by CMS earlier this year. DMS does not intend to submit any such waiver amendments to CMS this year nor make any substantive changes to the administrative regulation.

(c) Comment: Johnny Callebs, First Vice President of Public Policy, KAPP, stated:

“Page 27 – Section 7 (3) (I) 10 a, b ‘Be provided to recipients age twenty-two (22) or older; or be provided to recipients age sixteen (16) to twenty-one (21) as a transition process from school to work or adult support services’. Persons with intellectual or developmental disabilities have two options when it comes transitioning from high school: graduate between ages 18-21 or choose to remain in school until their 21st birthday. We recommend allowing all recipients over age 18 to access adult day training (ADT) services and those age 16-18 be allowed to receive ADT as a transition process from school to work or adult support services.”

(d) Response: DMS is currently performing a thorough review of all of its 1915(c) home and community based waiver programs to determine the changes needed to comply with a rule that the Centers for the Medicare and Medicaid Services (CMS) issued earlier this year regarding these programs. DMS is also trying to determine the amount of increased costs DMS will experience associated with complying with the rule.

DMS's preliminary belief is that compliance will increase DMS's expenditures significantly and DMS is facing a substantial budget deficit for the current state fiscal year.

Each state has five (5) years to bring each 1915(c) home and community based waiver program into compliance with the new rule. The requested change would necessitate an amendment to the corresponding 1915(c) home and community based services waiver. Submitting an amendment to the waiver would expose the entire waiver to coercion

from CMS (who reviews waivers and waiver amendments and decides whether or not to approve them and to provide federal funds) to bring the waiver in full compliance with the requirements in the HCBS rule issued by CMS earlier this year. DMS does not intend to submit any such waiver amendments to CMS this year nor make any substantive changes to the administrative regulation.

(12) Subject: Consumer-Directed Option

(a) Comment: Johnny Callebs, First Vice President of Public Policy, KAPP, stated:

“Page 35 – Section 8– The Consumer-Directed Option (CDO) is prone to abuse and is frequently manipulated and corrupted by the workers of the waiver recipients (mainly families). Some, but not all, families seek out CDO services so they can get paid to care for their son, daughter, or other family member. Many of them would provide the same service in a non-funded system as a natural support. We recommend incorporating the same regulatory language used in 907 KAR 12:010 that spells out the criteria by which family members and a legally responsible individual may be approved to provide a service.”

(b) Response: DMS is currently performing a thorough review of all of its 1915(c) home and community based waiver programs to determine the changes needed to comply with a rule that the Centers for the Medicare and Medicaid Services (CMS) issued earlier this year regarding these programs. DMS is also trying to determine the amount of increased costs DMS will experience associated with complying with the rule.

DMS's preliminary belief is that compliance will increase DMS's expenditures significantly and DMS is facing a substantial budget deficit for the current state fiscal year.

Each state has five (5) years to bring each 1915(c) home and community based waiver program into compliance with the new rule. The requested change would necessitate an amendment to the corresponding 1915(c) home and community based services waiver. Submitting an amendment to the waiver would expose the entire waiver to coercion from CMS (who reviews waivers and waiver amendments and decides whether or not to approve them and to provide federal funds) to bring the waiver in full compliance with the requirements in the HCBS rule issued by CMS earlier this year. DMS does not intend to submit any such waiver amendments to CMS this year nor make any substantive changes to the administrative regulation.

(c) Comment: Johnny Callebs, First Vice President of Public Policy, KAPP, stated:

“Page 41 – Section 8– Currently when recipients choose CDO, in whole or blended services, they lose their Case Manager and must select a Support Broker. There is no option or personal choice in the matter. A Case Manager gets reimbursed at \$50.00 per unit, with a cap of \$200.00 per month. A Support Broker is reimbursed at \$265.00 per month. We recommend that recipients be allowed to exercise freedom of choice and

keep their case manager when choosing CDO blended services (as allowed in 907 KAR 12:010) and that case managers be reimbursed the same as support brokers when managing CDO blended services.”

(d) Response: DMS is currently performing a thorough review of all of its 1915(c) home and community based waiver programs to determine the changes needed to comply with a rule that the Centers for the Medicare and Medicaid Services (CMS) issued earlier this year regarding these programs. DMS is also trying to determine the amount of increased costs DMS will experience associated with complying with the rule.

DMS's preliminary belief is that compliance will increase DMS's expenditures significantly and DMS is facing a substantial budget deficit for the current state fiscal year.

Each state has five (5) years to bring each 1915(c) home and community based waiver program into compliance with the new rule. The requested change would necessitate an amendment to the corresponding 1915(c) home and community based services waiver. Submitting an amendment to the waiver would expose the entire waiver to coercion from CMS (who reviews waivers and waiver amendments and decides whether or not to approve them and to provide federal funds) to bring the waiver in full compliance with the requirements in the HCBS rule issued by CMS earlier this year. DMS does not intend to submit any such waiver amendments to CMS this year nor make any substantive changes to the administrative regulation.

(13) Subject: Incident Reporting Process

(a) Comment: Johnny Callebs, First Vice President of Public Policy, KAPP, stated:

“Pages 42- 43 – Section 11 – We recommend changing the incident reporting process to mirror 907 KAR 12:010 to promote uniformity of risk management functions across waivers. reporting process to mirror 907 KAR 12:010 to promote uniformity of risk management functions across waivers.”

(b) Response: DMS is currently performing a thorough review of all of its 1915(c) home and community based waiver programs to determine the changes needed to comply with a rule that the Centers for the Medicare and Medicaid Services (CMS) issued earlier this year regarding these programs. DMS is also trying to determine the amount of increased costs DMS will experience associated with complying with the rule.

DMS's preliminary belief is that compliance will increase DMS's expenditures significantly and DMS is facing a substantial budget deficit for the current state fiscal year.

Each state has five (5) years to bring each 1915(c) home and community based waiver program into compliance with the new rule. The requested change would necessitate an amendment to the corresponding 1915(c) home and community based services waiver.

Submitting an amendment to the waiver would expose the entire waiver to coercion from CMS (who reviews waivers and waiver amendments and decides whether or not to approve them and to provide federal funds) to bring the waiver in full compliance with the requirements in the HCBS rule issued by CMS earlier this year. DMS does not intend to submit any such waiver amendments to CMS this year nor make any substantive changes to the administrative regulation.

(c) Comment: Johnny Callebs, First Vice President of Public Policy, KAPP, stated:

“Page 51 Section 16 (j) – The Michelle P Waiver Incident Report Form has been updated since April 2, 2007. The latest revision is May 2013.”

(d) Response: DMS is updating the incorporated material, via an “amended after comments” administrative regulation, by incorporating the May 2013 version of the form.

SUMMARY OF STATEMENT OF CONSIDERATION
AND
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR 1:835 and is amending the administrative regulation as follows:

Page 3

Section 1(9) and 1(10)

Lines 1 to 4

After “(9)”, delete the remainder of subsection (9) and delete “(10)”.

Page 3

Section 1(11), 1(12), 1(13), 1(14), 1(15), and 1(16)

Lines 9, 10, 16, 17, 18, and 19

Renumber these six (6) subsections by inserting “(10)”, “(11)”, “(12)”, “(13)”, “(14)”, and “(15)”, respectively, and by deleting “(11)”, “(12)”, “(13)”, “(14)”, “(15)”, and “(16)”, respectively.

Page 4

Section 1(17)

Line 13

Renumber this subsection by inserting “(16)” and by deleting “(17)”.

Page 5

Section 1(18), 1(19), 1(20), 1(21), and 1(22)

Lines 1, 2, 3, 6, and 8

Renumber these five (5) subsections by inserting “(17)”, “(18)”, “(19)”, “(20)”, and “(21)”, respectively, and by deleting “(18)”, “(19)”, “(20)”, “(21)”, and “(22)”,

respectively.

Page 6

Section 1(23), 1(24), 1(25), and 1(26)

Lines 1, 4, 6, and 9

Renumber these four (4) subsections by inserting "(22)", "(23)", "(24)", and "(25)", respectively, and by deleting "(23)", "(24)", "(25)", and "(26)", respectively.

Page 6

Section 1(27)

Line

Before "(27)", insert the following:

(26) "Licensed psychologist" means an individual who:

(a) Currently possesses a licensed psychologist licensed in accordance with KRS 319.010(6); and

(b) Meets the licensed psychologist requirements established in 201 KAR Chapter 26.

After "(27)", insert the following:

"Licensed psychological practitioner" means an individual who:

(a) Meets the requirements established in KRS 319.053; or

(b) Is a certified psychologist with autonomous functioning.

(28)

Page 6

Section 1(28), 1(29), 1(30), and 1(31)

Lines 18, 20, 21, and 22

Renumber these four (4) subsections by inserting "(29)", "(30)", "(31)", and "(32)", respectively, and by deleting "(28)", "(29)", "(30)", and "(31)", respectively.

Page 7

Section 1(32), 1(33), 1(34), 1(35), 1(36), 1(37), 1(38), 1(39), 1(40), 1(41), and 1(42)

Lines 1, 2, 6, 7, 12, 13, 14, 16, 18, 21, and 22

Renumber these eleven (11) subsections by inserting "(33)", "(34)", "(35)", "(36)", "(37)", "(38)", "(39)", "(40)", "(41)", "(42)", and "(43)", respectively, and by deleting "(32)", "(33)", "(34)", "(35)", "(36)", "(37)", "(38)", "(39)", "(40)", "(41)", and "(42)", respectively.

Page 8

Section 1(43), 1(44), and 1(45)

Lines 1, 2, and 4

Renumber these three (3) subsections by inserting "(44)", "(45)", and "(46)", respectively, and by deleting "(43)", "(44)", and "(45)", respectively.

Page 8

Section 1(46)

Line 5

Before "(46)", insert the following:

(47) "State plan" is defined by 42 C.F.R. 400.203.

(48)

Delete "(46)".

Page 8

Section 1(47) and 1(48)

Lines 16 and 20

Renumber these two (2) subsections by inserting "(49)" and "(50)", respectively, and by deleting "(47)" and "(48)", respectively.

Page 9

Section 1(49)

Line 6

Renumber this subsection by inserting "(51)" and by deleting "(49)".

Page 22

Section 7(3)(g)5.b. and c.

Line 22

After "b." delete the remainder of clause b. and delete the notation "c.".

Page 23

Section 7(3)(g)5.d.

Line 2

Renumber this clause by inserting "c." and by deleting "d.".

Page 23

Section 7(3)(h)5.a.

Line 12

After "covers;" insert "and".

Page 23

Section 7(3)(h)5.b. and c.

Lines 13 to 15

After "b." delete the remainder of clause b. and delete the notation "c.".

Page 47

Section 11(9)

Line 11

After the period, insert a return and the following:

(10) An individual who is:

(a) At least twenty-one (21) years of age and who is placed on the Michelle P. Waiver Program waiting list shall be informed about and told how to apply for Medicaid state plan services for which the individual might qualify; or

(b) Under twenty-one (21) years of age and who is placed on the Michelle P. Waiver Program waiting list shall be informed about:

1. And told how to apply for Medicaid state plan services for which the individual might qualify; and

2. Early and Periodic Screening, Diagnostic, and Treatment services.

Page 50

Section 16(1)(b)

Line 15

After "Memorandum'," insert "August 2008".

Delete "February 2001".

Page 50

Section 16(1)(d)

Lines 18 to 19

After "Services'," insert "July 2008".

Delete "March 2007".

Page 51

Section 16(1)(e)

Line 1

After "Form'," insert "July 2008".

Delete "January 2000".

Page 51

Section 16(1)(f)

Line 3

After "Assessment'," insert "July 2008".

Delete "March 2007".

Page 51

Section 16(1)(g)

Line 5

After "(CDO)," insert "July 2008".

Delete "March 2007".

Page 51

Section 16(1)(h)

Line 6

After "Services'," insert "August 2014".

Delete "March 2007".

Page 51

Section 16(1)(i)

Lines 7 and 8

After "Contract'," insert "August 2010".

Delete "May 4, 2007".

Page 51

Section 16(1)(j)

Line 9

After "~~(j)~~"", insert "Michelle P. Waiver".

After "Form'", insert "May 2013".

Delete "April 2, 2007".

After "[~~edition~~];", insert "and".

Page 51

Section 16(1)(k) and (l)

Lines 10 and 11

After "~~(k)~~", delete the following:

"Michelle P. Waiver Medication Error Report", November 19, 2008; and

(l)